

NOTICE

**THE SWEETWATER COUNTY BOARD OF COUNTY COMMISSIONERS
WILL MEET ON TUESDAY, December 2, 2014 AT 8:30 A.M.
IN THE COMMISSIONERS' CHAMBERS
(TENTATIVE AND SUBJECT TO CHANGE)**

PLEASE ARRIVE 15 MINUTES EARLIER THAN YOUR SCHEDULED TIME

PRELIMINARY

8:30 CALL TO ORDER
QUORUM PRESENT
PLEDGE OF ALLEGIANCE
APPROVAL OF AGENDA
APPROVAL OF MINUTES: 11-18-14

ACCEPTANCE OF BILLS

Approval of County Vouchers/Warrants
Approval of Monthly Reports
Approval of Bonds

COMMISSIONER COMMENTS/REPORTS

8:40 Chairman Johnson
8:50 Commissioner West
9:00 Commissioner Bailiff
9:10 Commissioner Kolb
9:20 Commissioner Van Matre

COUNTY RESIDENT CONCERNS

9:30

ACTION/PRESENTATION ITEMS

9:40 Resolution Increasing the Salary of Chief Deputies

9:45 Board Appointments:
1. Events Complex
2. Park & Recreation

9:50 Ten Mile Water & Sewer District Appointments

- 10:00** Resolution to Approve Additional Holidays for County Employees and County Offices to be Closed
- 10:05** Approval of the FY 2015 Selective Traffic Enforcement Grant Agreement
- 10:10** Approval of Amendment One to the FY 2015 Community Services Block Grant (CSBG) Contract and Subgrantee Contract
- 10:15** Cancellation of Warrants per Wyoming State Statute 18-4-106
- 10:20** Adendum to Specific Purpose Tax MOU for the CDC
- 10:35** Approval of BLM Right of Way Grant No. WYW183919 (Yellowstone Road)
- 10:40** Health Insurance Plan Amendment
- 10:45** Simple Land Division for Orvie Berg and TLC Investments

OTHER

EXECUTIVE SESSION AS NEEDED

ADJOURN

[Per Wyo. Stat. §18-3-516\(f\) County information can be accessed on the County's website at www.sweet.wy.us](http://www.sweet.wy.us)

November 18, 2014

Green River, WY

The Board of County Commissioners met this day at 8:30 a.m. in Regular Session with all commissioners present. The meeting opened with the Pledge of Allegiance.

Approval of Agenda

Chairman Johnson requested to amend the agenda by moving executive session to 10:30 a.m. *Commissioner West moved to approve the agenda with the requested change. Commissioner Van Matre seconded the motion.* The motion carried.

Approval of Minutes: 11-4-14

Commissioner Kolb moved to approve the minutes dated November 4, 2014. Commissioner West seconded the motion. The motion carried.

Acceptance of Bills

Approval of County Vouchers/Warrants, Monthly Reports, and Abates/Rebates

Commissioner Kolb moved to approve the county vouchers/warrants, approval of the monthly reports, and the approval of the abates/rebates. Commissioner Bailiff seconded the motion. The motion carried.

WARRANT NO.s	PAYEE	DESCRIPTION	AMOUNT
62480-62518, 62519, 62536 & ADVICES	EMPLOYEES AND PAYROLL VENDORS	PAYROLL RUN	1,383,839.45
62520	BRIDGER VALLEY ELECTRIC ASSN	UTILITIES	135.84
62521	CENTURYLINK	PHONE BILL	8,422.21
62522	CITY OF GREEN RIVER	UTILITIES	2,703.81
62523	HOGAN & ASSOCIATES BUILDERS LLC	CONSTRUCTION	299,345.40
62524	PLAN ONE/ARCHITECTS	CONSTRUCTION/ REIMBURSABLES	9,371.94
62525	PURCHASE POWER	POSTAGE	83.56
62526	QUESTAR GAS	UTILITIES	5,039.06
62527	ROCK SPRINGS MUNICIPAL UTILITY	UTILITIES	4,308.20
62528	ROCK SPRINGS SW CO AIRPORT	RESOLUTION	18,810.00
62529	ROCKY MTN POWER	UTILITIES	6,712.44
62530	SWEETWATER CABLE TV	TV	115.05
62531	US POSTAL SERVICE (NEOPOST POSTAGE-ON CALL)	POSTAGE	6,000.00
62532	UNION TELEPHONE COMPANY INC	PHONE	42.89
62533	UNIVERSITY OF UTAH HEALTH CARE	MEDICAL	349.13
62534	WYOMING RETIREMENT SYSTEM	RETIREMENT	209,693.89
62535	WYOMING WASTE SERVICES - ROCK	UTILITIES	617.08
62537	ROCKY MTN POWER	UTILITIES	1,164.81
62538	UNION TELEPHONE COMPANY INC	PHONES/AIRCARDS/ EQUIPMENT	5,522.70
62539	WYOMING WASTE SERVICES - ROCK	UTILITIES	789.20
62540	1ST CONGREGATIONAL CHURCH	GENERAL ELECTION	75.00
62541	ACKERMAN, SHIRLEY A	GENERAL ELECTION	190.00
62542	ACKERMAN, STANLEY L.	GENERAL ELECTION	190.00
62543	ADAMS, MARY P	GENERAL ELECTION	190.00
62544	ALDRED, DAVID	GENERAL ELECTION	190.00
62545	ALDRED, GAIL C	GENERAL ELECTION	190.00
62546	ALLRED, JANE	GENERAL ELECTION	175.00
62547	ANDERSON, FRANCES E	GENERAL ELECTION	202.50
62548	ANDERSON, WENDY	GENERAL ELECTION	202.50
62549	ANGELI, JUANITA H	GENERAL ELECTION	240.00
62550	ARCHULETA, LACY	GENERAL ELECTION	190.00
62551	AULD, BETTY L	GENERAL ELECTION	190.00
62552	BACILA, GAYLE ANN	GENERAL ELECTION	225.00
62553	BACILA, NICK M.	GENERAL ELECTION	175.00
62554	BARBERO, DONALD G	GENERAL ELECTION	190.00
62555	BARBERO, SARA V.	GENERAL ELECTION	240.00
62556	BARNA, DONNA R	GENERAL ELECTION	175.00
62557	BARNEY, BRENDA JO	GENERAL ELECTION	175.00
62558	BARNEY, KARL R	GENERAL ELECTION	190.00
62559	BARTON, JENNIE MARIE	GENERAL ELECTION	206.80
62560	BAUMAN, DUANE A	GENERAL ELECTION	190.00
62561	BAUMAN, JOYCE	GENERAL ELECTION	190.00
62562	BEALL, BEA MARIE	GENERAL ELECTION	160.00
62563	BELCHER, VIVIAN S	GENERAL ELECTION	190.00
62564	BOEVERS, BEVERLY M	GENERAL ELECTION	190.00
62565	BONNABEL, MADELEINE F	GENERAL ELECTION	175.00
62566	BONSELL, IRIS	GENERAL ELECTION	192.24
62567	BORZEA, JAMES M	GENERAL ELECTION	190.00
62568	BOTELLO, CORA K	GENERAL ELECTION	234.60
62569	BRANDVIK, REED RYAN	GENERAL ELECTION	215.00
62570	BROUGH, LINDA AILEEN	GENERAL ELECTION	190.00
62571	BUSSE, MARY M.	GENERAL ELECTION	190.00
62572	CALLAS, LORNA J	GENERAL ELECTION	190.00

62573	CAMPHOUSE, AMANDA DAWN	GENERAL ELECTION	198.18
62574	CARTER, BETTY JEAN	GENERAL ELECTION	190.00
62575	CARTER, JAN E	GENERAL ELECTION	215.00
62576	CHRISTIANSEN, BONNIE LEE	GENERAL ELECTION	190.00
62577	CHRISTIANSEN, MARJORIE K	GENERAL ELECTION	190.00
62578	CHURCH, CHELSEA	GENERAL ELECTION	160.00
62579	CHURCHES INC	GENERAL ELECTION	75.00
62580	COATS, NOLA J	GENERAL ELECTION	175.00
62581	COLE, SHAWNA D	GENERAL ELECTION	240.00
62582	COTTER, DEBORAH K	GENERAL ELECTION	190.00
62583	COVELL, APRIL J	GENERAL ELECTION	190.00
62584	CRISTANELLI, EILEEN M	GENERAL ELECTION	190.00
62585	CROY, CORA ELEANOR	GENERAL ELECTION	215.00
62586	DAVIDSON, TERESA K	GENERAL ELECTION	190.00
62587	DAVIS, JOANN L	GENERAL ELECTION	190.00
62588	DAVIS, LENEDA LYNN	GENERAL ELECTION	240.00
62589	DEICHMUELLER, SEAN MICHAEL	GENERAL ELECTION	175.00
62590	DELAMBERT, SHIRLEY R.	GENERAL ELECTION	215.00
62591	DERNOVICH, MARJORIE L	GENERAL ELECTION	215.00
62592	DIVIS, DIANE L	GENERAL ELECTION	175.00
62593	EDGMON III, MARVIN W	GENERAL ELECTION	160.00
62594	ETIENNE, LAURA ANN	GENERAL ELECTION	175.00
62595	EVANS, JAMIE LYN	GENERAL ELECTION	240.00
62596	FEDRIZZI, MARILYN DIANE	GENERAL ELECTION	190.00
62597	FINLAYSON, BETTY L	GENERAL ELECTION	215.00
62598	FIRST UNITED METHODIST	GENERAL ELECTION	75.00
62599	FISCHER-DAY, KARRIE LOUISE	GENERAL ELECTION	215.00
62600	FORTNER, FULTON F	GENERAL ELECTION	190.00
62601	FOSTER, IRIS D	GENERAL ELECTION	201.20
62602	GEORGE, BERLINDA A	GENERAL ELECTION	215.00
62603	GOICOLEA, CAREEN KAYE	GENERAL ELECTION	190.00
62604	GREENE, DAWN	GENERAL ELECTION	190.00
62605	HAFNER, SUSANNAH	GENERAL ELECTION	190.00
62606	HANSEN, PHILLIP DENNIS SR	GENERAL ELECTION	190.00
62607	HARDY, MARY R	GENERAL ELECTION	190.00
62608	HARDY, RAY MILLER	GENERAL ELECTION	190.00
62609	HARGIS, CAROLYN	GENERAL ELECTION	190.00
62610	HARMON, TERI N	GENERAL ELECTION	200.00
62611	HAUGHEY, CLEONE A	GENERAL ELECTION	175.00
62612	HENDERSON, ZOANNE P	GENERAL ELECTION	190.00
62613	HOLY SPIRIT CATHOLIC COMMUNITY	GENERAL ELECTION	150.00
62614	HOOTON, LEAH LOUISE	GENERAL ELECTION	225.00
62615	HUECKSTAEDT, RICHARD E	GENERAL ELECTION	129.22
62616	JACKSON, PAMELA S	GENERAL ELECTION	240.00
62617	JASPERSON, YVONNE J	GENERAL ELECTION	181.72
62618	JENKINS, SHERRY DAHN	GENERAL ELECTION	212.40
62619	JEREB, MARY RUTH	GENERAL ELECTION	190.00
62620	JOHNSON, BEVERLY E	GENERAL ELECTION	201.20
62621	JOHNSON, ELSA MAE	GENERAL ELECTION	175.00
62622	JOHNSON, KATHLEEN	GENERAL ELECTION	190.00
62623	K-MOTIVE & SPORTS	GENERAL ELECTION	75.00
62624	KEENER, JANICE	GENERAL ELECTION	190.00
62625	KELLEY, KAREN	GENERAL ELECTION	176.80
62626	KELLEY, PATRICK	GENERAL ELECTION	176.80
62627	KETTLE, KRISTI K	GENERAL ELECTION	190.00
62628	KNADJIAN, JANIS L	GENERAL ELECTION	190.00
62629	KROUPA, ERLING D	GENERAL ELECTION	200.00
62630	KROUPA, LESLIE A	GENERAL ELECTION	175.00
62631	LEIGH, JO ANN L	GENERAL ELECTION	200.00
62632	LIGHTNER, KAYLOU	GENERAL ELECTION	190.00
62633	LITTTRELL, BIRDIE L	GENERAL ELECTION	175.00
62634	LOGAN, DOROTHY M	GENERAL ELECTION	215.00
62635	LUCKEY, CAROLYN VIRGINIA	GENERAL ELECTION	190.00
62636	LYTLE, SHIRLEY ANN	GENERAL ELECTION	190.00
62637	MALSON, CAROLYN S	GENERAL ELECTION	190.00
62638	MCCAIN, SYLVIA M.	GENERAL ELECTION	190.00
62639	MCDERMOTT, ARIANN	GENERAL ELECTION	190.00
62640	MCFADDEN, MARGARET A	GENERAL ELECTION	190.00
62641	MCMURRY, ANGELA A.	GENERAL ELECTION	190.00
62642	MCMURRY, MERIAM M	GENERAL ELECTION	190.00
62643	MIDDLEMAS, BESSIE A	GENERAL ELECTION	160.00
62644	MILLER, DELMA JEAN	GENERAL ELECTION	190.00
62645	MITCHAM, NICOLE	GENERAL ELECTION	190.00
62646	MOON, WANDA A	GENERAL ELECTION	198.96
62647	MORGAN, DEBBRA LEA	GENERAL ELECTION	190.00
62648	MORRIS, CONNIE	GENERAL ELECTION	196.72
62649	MORRIS, JANICE HELEN	GENERAL ELECTION	175.00
62650	MORTENSEN, LOUISA J	GENERAL ELECTION	190.00
62651	MYSKA, CAROLE	GENERAL ELECTION	190.00
62652	NANCARROW, HOLLY CATHLEEN	GENERAL ELECTION	190.00
62653	NEWWEY, DONALD T	GENERAL ELECTION	175.00
62654	OEHLER, DEBORAH LYNNE	GENERAL ELECTION	175.00
62655	OLESON, JANET IRENE	GENERAL ELECTION	190.00
62656	ORTEGA, KAY LEE	GENERAL ELECTION	225.00

62657	ORTEGA, LEONARD C	GENERAL ELECTION	175.00
62658	PAUL, ALICE A	GENERAL ELECTION	190.00
62659	PAWLESKA, JOHN E	GENERAL ELECTION	160.00
62660	PERRY, LENORE S	GENERAL ELECTION	190.00
62661	PETTY, KAREN LYNN	GENERAL ELECTION	190.00
62662	POTTER, CHERYL	GENERAL ELECTION	175.00
62663	PREVEDEL, NORMA A	GENERAL ELECTION	220.60
62664	RIGANO, SUE ANN	GENERAL ELECTION	240.00
62665	RISLEY, JAMIE LYNN	GENERAL ELECTION	195.60
62666	ROBINSON, MARGIE KAY	GENERAL ELECTION	175.00
62667	ROMERO, LISA K	GENERAL ELECTION	190.00
62668	ROMERO-CARON, VIRGINIA	GENERAL ELECTION	190.00
62669	ROTH, VICTORIA G	GENERAL ELECTION	160.00
62670	ROWE, ROSEMARY	GENERAL ELECTION	215.00
62671	RUGGERA, JOANN B	GENERAL ELECTION	215.00
62672	SANDERS, KATHY FERRIN	GENERAL ELECTION	190.00
62673	SCHAEFER, ELIZABETH CLAIRE	GENERAL ELECTION	190.00
62674	SCHAEFER, MARJORIE J	GENERAL ELECTION	240.00
62675	SEYERSDAHL, LILA M	GENERAL ELECTION	196.72
62676	SEYMOUR, SHARON ANN	GENERAL ELECTION	190.00
62677	SHANEBROOK, JOHN G	GENERAL ELECTION	175.00
62678	SHANEBROOK, MERRILLYN E	GENERAL ELECTION	200.00
62679	SHEPARD, JANET L	GENERAL ELECTION	190.00
62680	SHUPE, LUCY E	GENERAL ELECTION	246.72
62681	SIMS, DIANA J	GENERAL ELECTION	175.00
62682	SLAGOWSKI, BRYNNE M	GENERAL ELECTION	290.00
62683	SLAGOWSKI, DAWN M	GENERAL ELECTION	190.00
62684	SMITH, GLENDA D	GENERAL ELECTION	175.00
62685	SMITH, SHERIE G	GENERAL ELECTION	225.00
62686	STEVENSON, BESSIE M	GENERAL ELECTION	190.00
62687	STOCKER, RACHAEL ANN	GENERAL ELECTION	175.00
62688	STOCKER, WILLIAM FREDERICK	GENERAL ELECTION	175.00
62689	STOVER, CHERYL L	GENERAL ELECTION	175.00
62690	STRANNIGAN, ELIZABETH J	GENERAL ELECTION	220.60
62691	TEBEDO, MARY K	GENERAL ELECTION	190.00
62692	THOMAN, LAURIE LYNN	GENERAL ELECTION	246.00
62693	THOMAN, MARY A	GENERAL ELECTION	271.00
62694	THOMPSON, DIANA M	GENERAL ELECTION	190.00
62695	THOMSON, BRUCE R	GENERAL ELECTION	196.16
62696	THOMSON, JUDY KAY	GENERAL ELECTION	246.16
62697	THORNTON, ERIK WILLIAM	GENERAL ELECTION	215.00
62698	TOMASINI, BARBARA A	GENERAL ELECTION	190.00
62699	TOMASINI, CARL L	GENERAL ELECTION	190.00
62700	TRUJILLO, LILLIAN	GENERAL ELECTION	190.00
62701	TRUJILLO, MARTHA P	GENERAL ELECTION	215.00
62702	VARLEY, AMANDA R	GENERAL ELECTION	190.00
62703	VARLEY, MEAGAN MARY	GENERAL ELECTION	190.00
62704	VARLEY, ROGER D.	GENERAL ELECTION	215.00
62705	VIGIL, MARY JEAN	GENERAL ELECTION	190.00
62706	WADSWORTH, UVA JEANNIE	GENERAL ELECTION	190.00
62707	WALES-ALLEN, ERICA N	GENERAL ELECTION	240.00
62708	WALKER, JUDITH ANN	GENERAL ELECTION	190.00
62709	WALKER, MICHAEL LEE	GENERAL ELECTION	190.00
62710	WALL, ANITA F	GENERAL ELECTION	240.00
62711	WARDELL, KRISTY EILEEN	GENERAL ELECTION	246.00
62712	WATERS, LAVANETTA P	GENERAL ELECTION	231.80
62713	WATTS, BRENDA J	GENERAL ELECTION	190.00
62714	WEBB, GAYLE L	GENERAL ELECTION	190.00
62715	WHITE, JOAN ELIZABETH	GENERAL ELECTION	190.00
62716	WILLIAMS, KELLY M	GENERAL ELECTION	175.00
62717	WIRE, DIANA LYNN	GENERAL ELECTION	190.00
62718	WOODS, WINONA TOONE	GENERAL ELECTION	190.00
62719	WUERTLEY, ADENE	GENERAL ELECTION	190.00
62720	YOUNG, NANCY A	GENERAL ELECTION	190.00
62721	ZEBRE, LOIS T	GENERAL ELECTION	215.00
62722	ZIMMERMAN, CHERYL E	GENERAL ELECTION	175.00
62723	ACE HARDWARE	SUPPLIES	363.41
62724	ACE HARDWARE #11263-C	SUPPLIES	368.27
62725	ALLEN, CHERYL	MILEAGE/MEALS	339.48
62726	ALPINE PURE BOTTLED WATER	WATER/RENTAL	119.00
62727	ALPINE PURE SOFT WATER	SALT	253.75
62728	ARROWHEAD CONCRETE INC	CONCRETE BLOCKS	6,540.00
62729	AUTOSPA INC	CAR WASH	56.60
62730	BADGER DAYLIGHTING CORP	MAINTENANCE	3,000.00
62731	BATTERY SYSTEMS	BATTERIES	57.56
62732	BENJAMIN FOODS LLC	INMATE FOOD	4,311.26
62733	BENNETT PAINT & GLASS	SUPPLIES	32.97
62734	BOSCHETTOS/KRONSKIS	MEALS	1,191.84
62735	CAPITAL BUSINESS SYSTEMS INC	MAINTENANCE	36.88
62736	CARQUEST AUTO PARTS	PARTS	2,128.50
62737	CARRIER CORPORATION	MAINTENANCE	5,943.65
62738	CARSON, ANTHONY S	MEALS	87.38
62739	COPIER & SUPPLY CO INC	MAINTENANCE	1,023.28
62740	CREATIVE CULTURE INSIGNIA LLC	SUPPLIES	441.25

62741	DAN'S TIRE SERVICE	TIRES	4,626.80
62742	DAVE'S APPLIANCE SERVICE	MAINTENANCE	140.00
62743	DELL MARKETING L P	LICENSES	111,589.48
62744	DELTA DENTAL	FEES	2,158.00
62745	DESERT VIEW ANIMAL HOSPITAL	PRESCRIPTION	197.12
62746	DIVERSIFIED INSURANCE BEN SERV LLC	FEES	2,099.08
62747	DIVERSIFIED INSURANCE BEN SERV LLC	FEES	12,000.00
62748	TIMOTHY A EAGLER, ATTORNEY AT LAW LLC	FEES	1,780.00
62749	EDA ARCHITECTS INC	SERVICES	3,097.40
62750	ELECTRICAL CONNECTIONS INC	REPAIRS	2,379.57
62751	F B MCFADDEN WHOLESALE COMPANY	SUPPLIES	452.10
62752	F B MCFADDEN WHOLESALE COMPANY	COMMISSARY/CREDIT	6,486.57
62753	FIRST CHOICE FORD	PARTS	30.52
62754	FREMONT MOTOR ROCK SPRINGS INC	RETURN/PART	1,065.24
62755	G & K SERVICES	SERVICES	292.52
62756	GOLDEN HOUR SENIOR CITIZENS CENTER	MEALS	720.00
62757	GRAINGER	EQUIPMENT	720.47
62758	GREAT WESTERN PARK & PLAYGROUND	EQUIPMENT	4,556.55
62759	GREEN RIVER STAR	AD	4,105.13
62760	HCC LIFE INSURANCE COMPANY	FEES	27,630.88
62761	HIGH COUNTRY BEHAVIORAL HEALTH	RENT	1,000.00
62762	HIGH SECURITY LOCK & ALARM	SUPPLIES	670.25
62763	HOMAX OIL SALES INC	FUEL	32,592.54
62764	HOSE & RUBBER SUPPLY	PARTS	531.71
62765	HOSPICE OF SWEETWATER COUNTY	BUDGET ALLOCATION	26,225.00
62766	HOWARD SUPPLY COMPANY, LLC	PARTS	224.74
62767	INBERG-MILLER ENGINEERS	SPEED STUDIES	3,261.04
62768	INDO AMERICAN ENGINEERING INC	SERVICE	37,984.75
62769	INDUSTRIAL HOIST AND CRANE	INSPECTION	171.38
62770	INDUSTRIAL SUPPLY	SUPPLIES	403.30
62771	INTERNATIONAL CODE COUNCIL INC	BOOK	54.00
62772	JACK'S TRUCK & EQUIPMENT	PARTS	469.10
62773	JENNY SERVICE CO	INMATE FOOD	2,009.36
62774	JOHNSON, WALLY J	MILEAGE/MEALS	206.52
62775	KAMAN INDUSTRIAL TECHNOLOGIES	SUPPLIES	474.75
62776	KOIVUSAARI, REIJO	MEALS	23.53
62777	LAWN WORLD	MAINTENANCE	11,870.00
62778	LEVITT, LARRY	OFFICE SUPPLIES	19.07
62779	LEWIS AND LEWIS INC	ROAD WORK	488,913.30
62780	LYLE SIGNS INC	SUPPLIES	227.01
62781	MACY'S TRUCK REPAIR INC	PARTS	489.42
62782	MATHEY LAW OFFICE - ASSIGNEE	FEES	5,030.00
62783	MATTHEW BENDER & CO INC	OFFICE SUPPLIES	44.44
62784	MCGEE, HEARNE & PAIZ LLP	AUDIT	12,500.00
62785	MCKEE FOODS CORPORATION	INMATE FOOD	264.48
62786	MEADOW GOLD DAIRIES SLC	INMATE FOOD	1,268.75
62787	MOUNTAINLAND SUPPLY COMPANY	REPAIR	41.95
62788	NACVSO	DUES	120.00
62789	NAPA AUTO PARTS UNLIMITED	PARTS	1,298.98
62790	NEW FRONTIER IMAGING LLC	INMATE MEDICAL	270.00
62791	NICHOLAS & COMPANY	SUPPLIES	1,250.62
62792	NORCO INC	PARTS	59.09
62793	NUTECH SPECIALTIES INC	SUPPLIES	232.16
62794	PABLO & PICASSO PAINTING	PAINTING	5,119.12
62795	PACIFIC STEEL & RECYCLING	SUPPLIES	88.85
62796	PINEDA, BOBBY WAYNE	FEES	4,710.00
62797	PLAINSMAN PRINTING & SUPPLY	OFFICE SUPPLIES	314.20
62798	PM AUTOGLASS INC	MAINTENANCE	180.00
62799	PROFESSIONAL SYSTEMS TECH INC	REPAIRS	2,167.50
62800	PUBLIC DEFENDER	RENT	2,500.00
62801	QUILL CORPORATION	EQUIPMENT	485.59
62802	REAL KLEEN INC	SUPPLIES	857.90
62803	ROCK SPRINGS NEWSPAPERS INC	SUBSCRIPTION	127.00
62804	ROCK SPRINGS NEWSPAPERS INC	ADS	11,411.65
62805	ROCK SPRINGS NEWSPAPERS INC	ADS	166.41
62806	ROCK SPRINGS NEWSPAPERS INC	ADS	88.48
62807	ROCK SPRINGS WINLECTRIC CO	PARTS	164.00
62808	ROCK SPRINGS WINNELSON CO	MAINTENANCE	1,874.96
62809	RON'S ACE RENTALS	RENTAL	2,084.50
62810	SECRETARY OF STATE	NOTARY	30.00
62811	SHADOW MOUNTAIN WATER OF WY	RENT	47.40
62812	SPECIALTY RETAIL SHOPS HOLDING CORP	SUPPLIES	83.89
62813	SIX STATES DISTRIBUTORS INC	PARTS	151.71
62814	SMYTH PRINTING INC	OFFICE SUPPLIES	353.47
62815	STAPLES ADVANTAGE - DEPT LA	OFFICE SUPPLIES	68.49
62816	STERLING COMMUNICATIONS & ELECTRONICS	RENT	925.00
62817	STOTZ EQUIPMENT	PARTS/LABOR	1,775.30
62818	SWANK MOTION PICTURES INC	LICENSE	467.50
62819	SWEETWATER CO CLERK DIST COURT	FEE	20.00
62820	SWEETWATER CO SOLID WASTE DISPOSAL	E-WASTE	232.00
62821	SWEETWATER COUNTY HEALTH BOARD	BUDGET ALLOCATION	103,218.92
62822	SWEETWATER COUNTY INSURANCE	CLAIMS	313,976.41
62823	SWEETWATER COUNTY WEED & PEST DIST	SUPPLIES	35.00

62824	SWEETWATER TROPHIES	SHIPPING	165.57
62825	THE RADAR SHOP INC	SUPPLIES	1,416.00
62826	THE RADIO NETWORK	AD	1,296.00
62827	THE SHERWIN-WILLIAMS CO	PAINT	468.44
62828	THE TIRE DEN INC	PARTS	1,047.81
62829	THE UPS STORE - #3042	SHIPPING	145.15
62830	THOMSON REUTERS-WEST PAYMENT CTR	SUBSCRIPTION	6,316.50
62831	TRANSUNION RISK AND ALTERNATIVE	SUPPLIES/LATE CHARGE	110.25
62832	U S FOODS INC	INMATE FOOD	2,848.49
62833	UINTA ENGINEERING & SURVEYING INC	EQUIPMENT	9,300.00
62834	ULINE	SUPPLIES	46.14
62835	UMR INC	FEES	12,095.84
62836	UNIVERSITY OF UTAH HOSPITALS/CLINIC	MEDICAL RECORDS	15.00
62837	VAUGHN'S PLUMBING & HEATING	MAINTENANCE	5,290.85
62838	VEHICLE LIGHTING SOLUTIONS INC	SUPPLIES	70.50
62839	VISION SERVICE PLAN	PREMIUMS	4,986.05
62840	WAXIE SANITARY SUPPLY	SUPPLIES	2,478.75
62841	WEST SIDE WATER & SEWER DISTRICT	FEES	2,199.50
62842	WHISLER CHEVROLET COMPANY	PARTS	335.35
62843	WHITE MOUNTAIN LUMBER & RENTAL	REPAIR	51.72
62844	WILLIAMS SCOTSMAN INC	RENT	346.42
62845	WINDOW AND DOOR STORE	REPAIR	3,356.03
62846	WINTER EQUIPMENT COMPANY INC	EQUIPMENT	16,314.53
62847	WYOMING DEPT OF TRANSPORTATION	PERU BRIDGE	108.42
62848	WYOMING MACHINERY COMPANY	PARTS	4,315.11
62849	WYOMING STATE BAR	FEES	3,212.50
62850	XYBIX SYSTEMS INC	FURNITURE	12,923.77
62851	YWCA OF SWEETWATER COUNTY	BUDGET ALLOCATION	121,021.81
GRAND TOTAL:			3,507,027.36

TAXPAYER	VALUATION	TAXPAYER	VALUATION
NUCO2	-389	WAY PRODUCTION THE	-466
MULINEX JESSICA	-173	WAY PRODUCTION THE	-456
POTTER DAVID A JR	-353	WAY PRODUCTION THE	-432
BP AMERICA PROD CO	-2,500	WAY PRODUCTION THE	-409
BP AMERICA PROD CO	-2,158	WAY PRODUCTION THE	-357
BP AMERICA PROD CO	-265,267	WAY PRODUCTION THE	-317
BP AMERICA PROD CO	-1,383	WAY PRODUCTION THE	-274
HRM RESOURCES LLC	-10,365	WAY PRODUCTION THE	-228
TOC-ROCKY MOUNTAIN INC	-258	WAY PRODUCTION THE	-187

Commissioner Comments/Reports

Commissioner Van Matre

Commissioner Van Matre reported that the Veteran's Service Office is making arrangements to hold a Veteran Town Hall meeting on November 24, 2014 to discuss health care services with the Veterans Administration. Commissioner Van Matre explained that he and Commissioner West will be discussing the new location for the Veteran's Service office and the Juvenile Probation office. Commissioner Van Matre explained that he, along with IT Director Tim Knight, Commissioner West and Human Resource Director Garry McLean have been working together on facility services to various departments.

Chairman Johnson

Chairman Johnson extended his congratulations to those who prevailed in the election. Chairman Johnson addressed the closure of the courthouse during the upcoming holidays. Following discussion, *Commissioner Bailiff moved to give half day off for Christmas Eve and New Year's Eve and the full day off on the Friday's following Christmas and New Year's.* *Commissioner Van Matre seconded the motion.* The motion carried.

Chairman Johnson entertained a motion to amend the deadline date to be placed on the Board of County Commissioners agenda from Wednesday, November 26, 2014 to Tuesday, November 25, 2014 due to the Thanksgiving holiday. *Commissioner Kolb moved to amend the cutoff date to November 25, 2014.* *Commissioner West seconded the motion.* The motion carried.

Chairman Johnson explained that he was elected as the Wyoming Landscape Conservation Initiative (WLCI) Vice Chairman. Chairman Johnson explained that he would be leaving the commissioners meeting early to attend the Wyoming Association of Conservation District annual award luncheon where he will accept the award for 2014 outstanding elected official. Chairman Johnson explained that the award is credited to the Sweetwater County Board of County Commissioners working together and that he would accept the award on behalf of the commission. Chairman Johnson requested that Commissioner Kolb be acting chairman during his absence.

Commissioner West

Commissioner West provided an update on the Health and Human Services building and noted that the completion date is scheduled for the middle of December. Commissioner West noted that he met with McGee, Hearne and Paiz auditor Amber Nuse.

Commissioner Bailiff

Commissioner Bailiff noted that he spoke with Ambulance Service Board Chairman Lyle Armstrong regarding being placed on the agenda for the needs assessment grant. Commissioner Bailiff explained that he and Commissioner West received a complaint relative to the jail and expressed that they did not have authority over the jail but would pass the information to the appropriate staff. Lastly, Commissioner Bailiff reported that he attended the Library Board meeting.

Commissioner Kolb

Commissioner Kolb reported that he attended the Planning and Zoning meeting, attended the Airport Board meeting and noted that a special conference call concerning Sky West has been scheduled. Commissioner Kolb further reported that he attended a meeting at the Events Complex regarding the future of the National High School Finals Rodeo. Commissioner Kolb expressed his displeasure with the Rocket Miner article titled "Sweetwater County plows take a holiday" noting that the county maintains roads regardless of holidays. Commissioner Kolb addressed the courtroom facility upgrade and the commission concurred that a workshop should be held. In closing, Commissioner Kolb expressed his appreciation to Commissioner Bailiff for his service.

County Resident Concerns

Chairman Johnson opened county resident concerns. County Treasurer Robb Slaughter expressed his appreciation to the commission for extending the holiday time off for employees. Hearing no further comments, the hearing was closed.

Action/Presentation Items

Board Appointments

Community Fine Arts (to fill an unexpired term through 7-1-16)

Following discussion, *Commissioner Kolb moved to appoint Colleen Beutel. Commissioner West seconded the motion.* The motion carried.

Joint Travel and Tourism (3 Year Term)

Following discussion, *Commissioner Van Matre moved to appoint Kent Porenta to the Joint Travel and Tourism Board. Commissioner Bailiff seconded the motion.* The motion was defeated with Commissioners Kolb, Johnson and West voting nay. *Commissioner Bailiff moved to appoint Deborah Alvarez. Commissioner West seconded the motion.* The motion carried.

Library (3 Year Term)

Following discussion, Chairman Johnson entertained a motion to re-appoint Timothy Winger. *Commissioner West so moved. Commissioner Bailiff seconded the motion.* The motion carried.

Southwest Counseling (to fill an unexpired term through 7-1-17)

Following discussion, *Commissioner West moved to appoint Kathy Luzmoor to the Southwest Counseling Board to fill the unexpired term of Richard Craver and this appointment will become effective January 1, 201. Commissioner Bailiff seconded the motion.* The motion carried.

Amendment One to the Contract between WYDOT and the SWCO Commission

Commissioner Kolb presented the amended contract between WYDOT and the Sweetwater County Commission explaining that, when the grant agreement was executed, the community shared percentage matches were rounded and, even though the total dollar amounts contained in the agreement were correct, the state percentages needed to be adjusted out four decimal points. Chairman Johnson entertained a motion to approve the Amendment One to the contract between WYDOT and the Sweetwater County Commission and authorize the Chairman to sign. *Commissioner Van Matre so moved. Commissioner Kolb seconded the motion.* The motion carried.

Break

Chairman Johnson called for a break.

County Resident Concerns

Due to being ahead of schedule during county resident concerns, Chairman Johnson re-opened county resident concerns. Combined Communications Joint Powers Board Executive Director Robin Etienne recognized Communicator Cheryl Johnson who was awarded dispatcher of the year from the Wyoming Peace Officers Association. The commission extended their appreciation to Ms. Johnson. Hearing no further comments, the hearing was closed.

Action/Presentation Items-Continued

Approval of Resolution - Formation and Trustees Election for High Desert Rural Healthcare District

County Clerk Dale Davis presented Resolution 14-11-CC-02. Following discussion, *Commissioner West moved to approve. Commissioner Kolb seconded the motion.* The motion carried.

RESOLUTION # 14-11-CC-02

WHEREAS, at a formation election and election of Trustees of the duly qualified electors of the High Desert Rural Health Care District, Sweetwater County, State of Wyoming (the 'District'), duly called and held on November 4, 2014, the formation question received a majority of the votes cast in favor of the formation, and five electors of the District received a majority of the votes cast for election to the Board of Trustees of the District.

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners, Sweetwater County, Wyoming;

Section 1. The formation election and election of Trustees held in the District on Tuesday, November 4, 2014, hereby is determined and declared to have been called, ordered and held in strict compliance with law.

Section 2. The majority of the votes cast were in favor of the following formation question:

“Shall a Rural Healthcare District be established in accordance with the Wyoming Special Rural Health Care Districts Act Section 35-2-701 through 709, of Wyoming Statutes 1977, as amended, and under the Special District Elections Act of 1994, Wyoming Statutes 22-29-101 through 601, to be known as the “High Desert Rural Healthcare District” with purpose of the district is to provide financial support for the Wamsutter Community Health Center in Wamsutter, Wyoming and health service support for Bairoil; to provide financial support for the Emergency Medical Services/Ambulance Service, based in Wamsutter, Wyoming; to provide financial support to the health care or health promotion related services and/or equipment for the residents, business and industries in the region; therefore if said district is created, the District Board of the High Desert Rural Healthcare District shall be authorized to annually levy a tax not to exceed two (2) mills on the dollar, in any one (1) year, of the assessed valuation of the taxable property within the High Desert Rural Healthcare for the purpose of operation said district?”

FOR: 147
AGAINST: 4

Section 3. The majority of the votes cast for Trustees at the election were for the persons named following and for the terms shown following:

TRUSTEE ELECTION:

FOR THE FOUR YEAR TERM (TWO TO BE ELECTED)

Bobbi L Amos	93
Lisa Colson	54
Sheri Lyon	83
Leneda Davis (Write-in)	1
Pat Angle (Write-in)	1
Jenny Shields (Write-in)	1

FOR THE TWO YEAR TERM (THREE TO BE ELECTED)

Jacquelyn L Angle	63
Michael Roehrs	41
Craig Staker	82
Emma D Waldner	103
Nate Nordin (Write-in)	1
Melvin Mathis (Write-in)	1
Joe Erickson (Write-in)	1
Budd Hetrick (Write-in)	1

The official certificate of election results is attached to this resolution.

NOW THEREFORE, the Board of Sweetwater County, Wyoming Commissioners RESOLVE that the boundaries of the High Desert Rural Healthcare District are as follows:

All that portion of Sweetwater County bounded on the north by the north line of Sweetwater County and on the east by the east line of Sweetwater County and on the south by the south line of Sweetwater County and on the west by the following described line:

Beginning at the S.W. Corner of T12N, R98W, thence northerly along the west line of T12N, R98W, T13N, R98W; T14N, R98W; T15N, R98W, to the N.W. Corner of T15N, R98W said Corner is also the S.E. Corner of Solid Waste District # 1;

thence northerly along the east and north line of Solid Waste District #1 as follows: northerly along the west line of T16N, R98W, to the N.W. Corner of said T16N, R98W;

thence westerly along the south line of T17N, R98W to the S.W. Corner of said T17N, R98W;

thence northerly along the west line of said T17N, R98W to the N.W. Corner of said T17N, R98W;

thence easterly along the south line of T18N, R98W to the S.E. Corner of Section 33, T18N, R98W;

thence northerly along the east line of Sections 33, 28, 21, 16, 9 and 4 of T18N, R98W and the east line of Sections 33, 28, 21, 16, 9 and 4 of T19N, R98W and the east lines of Sections 33, 28, 21, 16, 9 and 4 of T20N, R98W to the N.E. Corner of Section 4 T20N, R98W;

thence easterly along the north line of T20N, R98W to the S.W. Corner of T21N, R97W;

thence northerly along the west line of T21N, R97W to the N.W. Corner of said T21N, R97W;

thence westerly along the south line of T22N, R98W, and T22N, R99W to the S.W. Corner of said T22N, R99W, said corner is also the S.E. Corner of the Eden Valley Solid Waste District;

thence leaving the east and north line of the Solid Waste District #1 and following the east line of the Eden Valley Solid Waste District as follows: northerly along the west line of T22N, R99W; T23N, R99W; T24N, R99W to the N.W. Corner of said T24N, R99W;

thence westerly along the south line of T25N, R99W to the S.W. Corner of said T25N, R99W;

thence northerly along the west line of T25N, R99W and T26N, R99W to a point on the north line of Sweetwater County, said point is also the N.W. Corner of said T26N, R99W.

Said described land is located totally within Sweetwater County and the 6th Principal Meridian.

BE IT FURTHER RESOLVED, that Bobbie L Amos and Sheri Lyon were elected Trustees to the four-year term on the District's Board and Jacquelyn L Angle, Craig Staker and Emma D Waldner were elected Trustees to the two year term on the District's Board.

Witness our signatures and the seal of the County this 18th day of November 2014.

THE BOARD OF COUNTY COMMISSIONERS OF SWEETWATER COUNTY, WYOMING

Wally J. Johnson, Chairman

Gary Bailiff, Member

John K. Kolb, Member

Don Van Matre, Member

Reid O. West, Member

ATTEST:

Steven Dale Davis, County Clerk

ADOPTED AND APPROVED this 17th day of November, 2014.

SEAL

Wally J. Johnson, Chair

ATTEST:

Steven Dale Davis, County Clerk

Request to Replace Vacant Custodial Positions

Human Resource Director Garry McLean and Custodial Supervisor Karen Bailey requested authorization to replace vacant positions. *Commissioner West moved to grant the request. Commissioner Kolb seconded the motion.* The motion carried.

Interagency Agreement between Wyoming Department of Health, Division of Healthcare Financing and Sweetwater County Public Health Nursing

Commissioner West presented the Interagency Agreement between the Wyoming Department of Health, Division of Healthcare Financing and Sweetwater County Public Health Nursing. Following discussion, Chairman Johnson entertained a motion to approve the Interagency Agreement between the Wyoming Department of Health, Division of Healthcare Financing and Sweetwater County Public Health Nursing. *Commissioner West so moved. Commissioner Kolb seconded the motion.* The motion carried.

Request to Re-Staff Vacant Position at the Detention Center

Chairman Johnson explained that, with having a new Sheriff, no action should be taken until the new sheriff is sworn in. Human Resource Director Garry McLean explained that the position is for maintenance at the detention center. Following discussion, Chairman Johnson entertained a motion to table the request. *Commissioner Kolb moved to table. Commissioner West seconded the motion.* The motion carried.

Renewal of BLM Right of Way Grant #WYW77776 for Portions of County Road 4-27 (Aspen Mountain Road)

Public Works Director John Radosevich presented the BLM Right of Way Grant renewal. Chairman Johnson entertained a motion to approve the BLM Right of Way Grant #WYW77776 for portions of County Road 4-27 (Aspen Mountain Road) and authorize the Chairman to sign. *Commissioner Van Matre so moved. Commissioner West seconded the motion.* Following discussion, the motion carried.

Break

Chairman Johnson called for a break.

Approval of the FY 2014 Homeland Security Grant Program Award Agreements

Grants Manager Krisena Marchal and Sheriff Haskell presented the FY 2014 Homeland Security Grant Program and Award Agreements. Following discussion, Chairman Johnson entertained a motion to approve, and authorize the Chairman to sign, the FY 2014 Homeland Security Grant Program and Award Agreements. *Commissioner West so moved. Commissioner Van Matre seconded the motion.* The motion carried.

Other

Executive Session(s)-Personnel/Legal

Chairman Johnson entertained a motion to enter into executive session for legal and personnel. *Commissioner West so moved. Commissioner Kolb seconded the motion.* The motion carried. A quorum of the commission was present.

After coming out of executive session, Chairman Johnson explained that no action was required.

Lunch

Chairman Johnson recessed the meeting for lunch. After the lunch break, Acting Chairman Kolb opened the afternoon session.

Planning & Zoning- Public Hearing

Church & Dwight- Variance to Allow Landfill in Mineral Development Zoning District and Conditional Use Permit to Operate Landfill in Commercial Zoning District

Planner III Steve Horton provided the Planning & Zoning report and presented Resolution 14-11-ZO-01. Hathaway & Kunz Attorney Rick Thompson, Church & Dwight Environmental Specialist Stan Rose, Tim O'Farrell and Tim Nelson were also present. Following discussion, Acting Chairman Kolb opened the public hearing. Hearing no comments, the public hearing was closed. *Commissioner West moved to approve Resolution 14-11-ZO-01. Commissioner Bailiff seconded the motion.* The motion carried.

**RESOLUTION 14-11-ZO-01
CHURCH & DWIGHT CO., INC.
VARIANCE AND CONDITIONAL USE PERMIT
LANDFILL**

WHEREAS, Church & Dwight Co., Inc. has requested a Variance from Section 5 of the 2014 Zoning Resolution to allow a Landfill as a Conditional Use in the Mineral Development-1 Zone District and a Conditional Use Permit to allow the operation of a Landfill in accordance with Section 7 of the 2014 Zoning Resolution. Church & Dwight Co., Inc. is proposing to operate their landfill on approximately 28.5 acres of land owned by Church & Dwight Co., Inc. and described as being:

A piece or parcel of land located in the S 1/2 of the 1/4 of Section 30 and the N 1/2 of the NW 1/4 of Section 31, Township 19 North, Range 109 West, of the 6th Principal Meridian, Sweetwater County, Wyoming. Beginning at the Southwest Corner of Section 30, T19N, R109W; thence, N0°49'41"E, along the section line common to Section 25, T19N, R110W and Section 30, T19N, R109W, 231.08 feet to a point on said section line; thence, N78°15'52"E, 2251.27 feet to a point; thence, S0°11'19"W, 696.21 feet to a point on the section line common to Sections 30 and 31, T19N, R109W;

thence, S0°11'19"W, 100.00 feet to a point, said point is parallel and perpendicular to the Section Line of Sections 30 and 31, T19N, R109W; thence, N89°48'41"W along a line that is 100 feet South and parallel to the North Line of Section 31, T19N, R109W, 2206.44 feet to a point on the Section Line of Section 36, T19N, R110W, and Section 31, T19N, R109W; thence, N0°51'34"E along said Section Line, 100.00 feet to the point of beginning. Said piece or parcel of land contains 28.516 acres more or less.

WHEREAS, the Sweetwater County Board of County Commissioners held a public hearing in regards to this matter on November 18, 2014 and has given due consideration to the recommendation of the Planning and Zoning Commission and to all the evidence and testimony presented at the hearing;

NOW THEREFORE BE IT RESOLVED that the Sweetwater County Board of County Commissioners APPROVES the following:

1. A Variance to allow a Landfill to be operated as a Conditional Use in a Mineral Development-1 Zone District.
2. A Conditional Use Permit to allow a Landfill to be operated in accordance with Section 7 of the 2014 Zoning Resolution.
3. The Conditional Use Permit for the Landfill is approved provided all Wyoming Department of Environmental Quality requirements are met.

Dated this 18th day of November, 2014.

THE BOARD OF COUNTY COMMISSIONERS
OF SWEETWATER COUNTY, WYOMING

____ Absent _____
Wally J. Johnson, Chairman

Gary Bailiff, Member

John K. Kolb, Acting Chairman

Don Van Matre, Member

Reid O. West, Member

ATTEST:

Steven Dale Davis, County Clerk

Barbara and David Holgate- Variance Setback Requirements

Planner III Steve Horton provided the Planning & Zoning report and presented Resolution 14-11-ZO-02. Owners David and Barbara Holgate were present. Acting Chairman Kolb opened the public hearing. Hearing no comments, the public hearing was closed. Following discussion, *Commissioner Van Matre moved for approval of the variance from setback requirements by David and Barbara Holgate with the understanding that the four conditions of this request will have to be met. Commissioner West seconded the motion to approve Resolution 14-11-ZO-02.* The motion carried.

**RESOLUTION 14-11-ZO-02
DAVID AND BARBARA HOLGATE
VARIANCE FROM SETBACK REQUIREMENTS**

WHEREAS, David and Barbara Holgate are requesting a Variance from Section 5 of the 2014 Zoning Resolution to allow an 8 foot encroachment in the front setback, a 6 foot encroachment in the side setback and a 1 foot encroachment between buildings in order to construct a detached garage. David and Barbara Holgate are proposing to construct their garage on approximately 0.15 acres of land owned by Barbara Holgate and described as:

Clearview Acres Subdivision, 3rd Section, Block 6, Lot 3, Sweetwater County, Wyoming.

WHEREAS, the Sweetwater County Board of County Commissioners held a public hearing in regards to this matter on November 18, 2014 and has given due consideration to the recommendation of the Planning and Zoning Commission and to all the evidence and testimony presented at the hearing;

NOW THEREFORE BE IT RESOLVED that the Sweetwater County Board of County Commissioners APPROVES the Variance from the following Setback Requirements of the 2014 Zoning Resolution:

1. Front setback encroachment of 8 feet (20 foot requirement/12 foot actual).
2. East side setback encroachment of 6 feet (10 foot requirement/4 foot actual).
3. 4 foot spacing between buildings (5 foot requirement).
4. The proposed detached garage must be built with one hour rated construction wherever it encroaches within five feet of existing buildings.

Dated this 18th day of November, 2014.

THE BOARD OF COUNTY COMMISSIONERS
OF SWEETWATER COUNTY, WYOMING

Absent
Wally J. Johnson, Chairman

Gary Bailiff, Member

John K. Kolb, Acting Chairman

Don Van Matre, Member

Reid O. West, Member

ATTEST:

Steven Dale Davis, County Clerk

Action/Presentation Items Continued

Request to Proceed with Plat Vacation of Part of Covered Wagon Subdivision

Land Use Director Eric Bingham and REV, Inc. President Larry Fusselman requested approval to vacate a portion of Covered Wagon Park Subdivision located in Section 7, Township 18 North, Range 107 due to no public water and sewer available to develop. Following discussion, *Commissioner West moved to proceed with the request by Mr. Fusselman to vacate a portion of Covered Wagon Park Subdivision located in Section 7, Township 18 North, Range 107 West along with vacating the County Roads within that area with the exception of Riview Road. Commissioner Van Matre seconded the motion.* The motion carried.

Adjourn

There being no further business to come before the Board this day, the meeting was adjourned subject to the call of the Acting Chairman.

This meeting was recorded and is available from the County Clerk's office at the Sweetwater County Courthouse in Green River, Wyoming

THE BOARD OF COUNTY COMMISSIONERS
OF SWEETWATER COUNTY, WYOMING

Wally J. Johnson, Chairman

Gary Bailiff, Member

John K. Kolb, Member/Acting Chairman

Don Van Matre, Member

Reid O. West, Member

ATTEST:

Steven Dale Davis, County Clerk

	DATE	AMOUNT	WARRANT #S
EAL	11/21/2014	75,506.14	62852-62870
EAL	11/28/2014	410,797.65	
EAL	12/2/2014	366,706.56	
EAL			
EAL			
EAL			

	AMOUNT	Check #	Advice #
Payroll Run	5,724.13	62871	12757-12758
Payroll Run			
Payroll Run			

TOTAL AMOUNT \$858,734.48

Vouchers in the above amount are hereby approved and ordered paid this date of 12/02/2014

Wally J. Johnson, Chair

Gary Bailiff, Member

John K. Kolb, Member

Don Van Matre, Member

Attest:

County Clerk

Reid O. West, Member

Authorization for Monthly Reports
12-2-14

1. **County Clerk**
2. **Clerk of District Court**
3. **Sheriff's Office**

THE BOARD OF COUNTY COMMISSIONERS
FOR SWEETWATER COUNTY, WYOMING

Wally J. Johnson, Chairman

Gary Bailiff, Member

John K. Kolb, Member

Attest:

Donald Van Matre, Member

Steven Dale Davis, County Clerk

Reid O. West, Member

MONTHLY STATEMENT

Statement of the Earnings of Collections of STEVEN DALE DAVIS COUNTY CLERK within and for the County of Sweetwater, State of Wyoming, for the month ending October 2014 and reported to the Board of County Commissioners of said County.

COUNTY CLERK		
Recording Fees	16,133.00	
Marriage Licenses	720.00	
Chattel Mortgages	14,414.00	
Motor Certificates of Title	(1659 /TITLES) 24,885.00	23,226.00
Sale of County Property	-	
Miscellaneous Receipts	1,805.50	
Total Recolpts		57,957.50
		(1,659.00)
		56,298.50

STATE OF WYOMING)
) ss.
 COUNTY OF SWEETWATER)

I hereby certify that the above is a true and correct statement of the earnings of my office, or of moneys collected by me as such officer during the month above mentioned, and that the same has been by me paid into the County Treasury

Witness my hand and seal this 03 day of November 2014



/s/ Steven Dale Davis COUNTY CLERK

Rene Claxton DEPUTY

Examined and approved by the Board of County Commissioners, this _____ day of _____

Chairman

Commissioner

Commissioner

Monthly Statement

Statement of the earnings or collections of **Donna Lee Bobak** as **Clerk of District Court** within and for the county of Sweetwater, state of Wyoming, for the month ending:

SEPTEMBER, 2014

Reported to the Board of County Commissioners of said County.

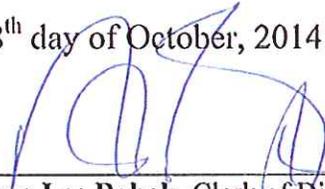
<u>CIVIL FEES</u>	\$	5,401.08
Code: DC		
<u>BOND FORFIETED</u>	\$.00
Code: FO		
<u>CRIMINAL FINES</u>	\$	27.34
Code: CF		
TOTAL EARNINGS	\$	5,428.42

Clerk of District Court Check #8280

STATE OF WYOMING
COUNTY OF SWEETWATER

I hereby certify that the above is a true and correct statement of the earnings of my office, or of moneys collected by me as such officer, during the month above mentioned, and that the same has been by me paid into the county treasury

Witness, my hand and seal this 28th day of October, 2014.



Donna Lee Bobak, Clerk of District Court



MONTHLY STATEMENT

Statement of the Earnings or Collections of Richard Haskell
 as Sheriff within and for the County of Sweetwater
 State of Wyoming, for the month ending October 31, 2014, and reported to the
 Board of County Commissioners of said County.

COUNTY CLERK,	Recording Fees, Marriage Licenses, Chattel Mortgages, Motor Certificates of Title, Sale of County Property, Miscellaneous Receipts, Total Receipts,		
CLERK, DISTRICT COURT,	Civil Fees, Probate Fees, Criminal fines and Costs, Miscellaneous Fees, Total Earnings,		
SHERIFF,		4281.00	
ASSESSOR,			
.....			
.....			
.....			

STATE OF WYOMING)
)ss.
 County of Sweetwater)

I hereby certify that the above is a true and correct statement of the earnings of my office, or of moneys collected by me as such officer during the month above mentioned, and that the same has been by me paid into the County Treasury.

WITNESS my hand and seal this 31 day of October, 2014.

Richard Haskell, County Sheriff

Richard Haskell

Authorization for Bonds

12-2-14

David E. Buller	Public Official- Treasurer	\$10,000.00
Dale Fisher	Clearview Improvement & Serv. Dist., Treasurer	\$25,000.00
Ann Rudoff	Sweetwater Board of Cooperative Serv., Treasurer	\$10,000.00
Vivian Shedden	Town of Granger, Clerk/Treasurer	\$15,000.00

THE BOARD OF COUNTY COMMISSIONERS
FOR SWEETWATER COUNTY, WYOMING

Wally J. Johnson, Chairman

Gary Bailiff, Member

John K. Kolb, Member

Attest:

Donald Van Matre, Member

Steven Dale Davis, County Clerk

Reid O. West, Member



Liberty Mutual Surety

National Bond Ctr
310 E. 96th Street
Indianapolis, IN 46240
888-844-2663 Fax: 866-547-4883

BW INSURANCE AGENCY INC
200 N CENTER ST
ROCK SPRINGS , WY 82901-7053

Agent Telephone: 307-352-3660

Bond Number: 32S125669

Cross Reference: 61980010000

DAVID E. BULLER
4070 JOHNSON WAY
GREEN RIVER, WY 82935

We appreciate having you as a Liberty Mutual customer and we would like to thank you for allowing us to serve your bonding needs. This letter is to confirm Liberty Mutual Surety has received payment for your renewing bond.

The effective date of your renewing bond begins: January 1, 2015

Please review the enclosed documents for accuracy. You must remit the original of the
Renew By Certificate and any supporting documents

required to your obligee.

If you have any questions regarding this bond or would like to discuss your future bond needs, please contact your Liberty Mutual agent.

Again, thank you for entrusting us with your bonding needs.

Sincerely,
National Bond Center

For additional information regarding Liberty Mutual insurance products, please visit www.libertymutual.com



National Bond Clr
310 E. 96th Street
Indianapolis, IN 46240
888-844-2663 Fax: 866-547-4883

CONTINUATION CERTIFICATE

To be attached to and form a part of surety bond number 32S125669 (the "Bond"), cross reference bond number 61980010000, for PUBLIC OFFICIAL - TREASURER

dated the 1st day of January, 2003, in the penal sum of \$ 10,000.00 Issued by AMERICAN STATES INSURANCE COMPANY as surety (the "Surety"), on behalf of DAVID E. BULLER as principal (the "Principal"), in favor of JAMESTOWN RIO VISTA FIRE DISTRICT, as obligee (the "Obligee").

The Surety hereby certifies that this Bond is continued in full force and effect until the 1st day of January, 2016, subject to all covenants and conditions of said Bond.

Said Bond has been continued in force upon the express condition that the full extent of the Surety's liability under said Bond, and this and all continuations thereof, for any loss or series of losses occurring during the entire time the Surety remains on said Bond, shall in no event, either individually or in the aggregate, exceed the penal sum of the Bond.

IN WITNESS WHEREOF, the Surety has set its hand and seal this 6th day of October, 2014

AMERICAN STATES INSURANCE COMPANY

(Surety)

By:

Timothy A. Mikolajewski

Timothy A. Mikolajewski
Assistant Secretary - Liberty Mutual Surety



BW INSURANCE AGENCY INC
200 N CENTER ST
ROCK SPRINGS , WY 82901-7053
307-352-3660

WESTERN SURETY COMPANY : ONE OF AMERICA'S OLDEST BONDING COMPANIES



Western Surety Company

OFFICIAL BOND AND OATH

KNOW ALL PERSONS BY THESE PRESENTS:

BOND No. OFF. 54932413

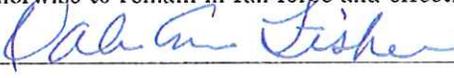
That we Dale Fisher of Rock Springs, Wyoming, as Principal, and WESTERN SURETY COMPANY, a corporation duly licensed to do business in the State of Wyoming, as Surety, are held and firmly bound unto Clearview Improvement & Service District, the State of Wyoming, in the penal sum of Twenty Five Thousand & no/100 DOLLARS (\$ 25,000.00),
(NOT VALID IF FILLED IN FOR MORE THAN \$50,000.00)

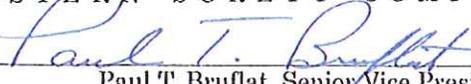
to which payment well and truly to be made, we bind ourselves and our legal representatives, jointly and severally, firmly by these presents.

Dated this 27th day of August, 2014

THE CONDITION OF THE ABOVE OBLIGATION IS SUCH, That whereas, the above bounden Principal was duly Appointed Elected to the office of Secretary/Treasurer in the Clearview Improvement & Service District, and State aforesaid for the term beginning August 27, 2014, and ending August 27, 2015.

NOW THEREFORE, If the above bounden Principal and his deputies shall faithfully, honestly and impartially perform all the duties of his said office of Secretary/Treasurer as is or may be prescribed by law, and shall with all reasonable skill, diligence, good faith and honesty safely keep and be responsible for all funds coming into the hands of such officer by virtue of his office; and pay over without delay to the person or persons authorized by law to receive the same, all moneys which may come into his hands by virtue of his said office; and shall well and truly deliver to his successor in office, or such other person or persons as are authorized by law to receive the same, all moneys, books, papers and things of every kind and nature held by him as such officer, the above obligation shall be void, otherwise to remain in full force and effect.


Principal

WESTERN SURETY COMPANY
By 
Paul T. Bruflat, Senior Vice President

ACKNOWLEDGMENT OF SURETY

STATE OF SOUTH DAKOTA }
County of Minnehaha } ss (Corporate Officer)

On this 27th day of August, 2014, before me, appeared Paul T. Bruflat to me personally known, being by me sworn, and did say that he is the aforesaid officer of WESTERN SURETY COMPANY, and that the seal affixed to said instrument is the corporate seal of said corporation, and that said instrument was signed and sealed on behalf of said corporation by authority of its Board of Directors, and said officer acknowledged said instrument to be the free act and deed of said corporation.



My Commission Expires December 7, 2014


Notary Public

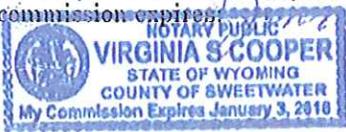
OATH OF OFFICE

I do solemnly swear (or affirm) that I will support, obey and defend the constitution of the United States, and the constitution of the state of Wyoming; that I have not knowingly violated any law related to my election or appointment, or caused it to be done by others; and that I will discharge the duties of my office with fidelity.

Dale Ann Fisher

State of Wyoming }
County of Sweetwater } ss

This Oath of Office was subscribed and sworn to before me by Dale Ann Fisher
on this 19th day of September, 2014
My commission expires January 3, 2018



Virginia S. Cooper
Notary Public, Wyoming

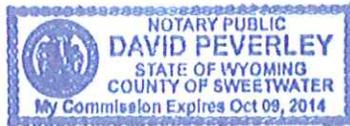
ACKNOWLEDGMENT OF PRINCIPAL

THE STATE OF WYOMING }
County of Sweetwater } ss

Dale Ann Fisher

On this 8th day of October, 2014, before me, personally
appeared Dale Ann Fisher, to me known to be the
person described in and who executed the foregoing instrument as Principal, and acknowledged that
the same was executed as her free act and deed.

My Commission expires
October 9th 2014 David Peverley
Notary Public, Wyoming



Wyoming



Western Surety Company

OFFICIAL BOND AND OATH

KNOW ALL PERSONS BY THESE PRESENTS:

Bond No. 54529164

That we Ann Rudoff,

of Rock Springs, Wyoming, as Principal, and WESTERN SURETY COMPANY, a corporation duly licensed to do business in the State of Wyoming, as Surety, are held and firmly bound

unto Sweetwater Board of Cooperative Services, the State of Wyoming, in the penal

sum of Ten Thousand and 00/100 DOLLARS (\$ 10,000.00), to which payment well and truly to be made, we bind ourselves and our legal representatives, jointly and severally, firmly by these presents.

Dated this 15th day of August, 2014.

THE CONDITION OF THE ABOVE OBLIGATION IS SUCH, That whereas, the above bounden
Principal was duly Appointed Elected to the office of Treasurer
in the Sweetwater Board of Cooperative Services,
and State aforesaid for the term beginning December 11, 2014, and ending
December 11, 2015.

NOW THEREFORE, If the above bounden Principal and his deputies shall faithfully, honestly and impartially perform all the duties of his said office of Treasurer as is or may be prescribed by law, and shall with all reasonable skill, diligence, good faith and honesty safely keep and be responsible for all funds coming into the hands of such officer by virtue of his office; and pay over without delay to the person or persons authorized by law to receive the same, all moneys which may come into his hands by virtue of his said office; and shall well and truly deliver to his successor in office, or such other person or persons as are authorized by law to receive the same, all moneys, books, papers and things of every kind and nature held by him as such officer, the above obligation shall be void, otherwise to remain in full force and effect.



Ann M. Rudoff
Principal

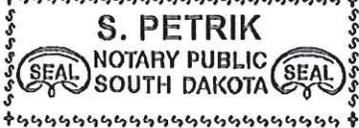
WESTERN SURETY COMPANY
By Paul T. Bruflat
Paul T. Bruflat, Senior Vice President

ACKNOWLEDGMENT OF SURETY
(Corporate Officer)

STATE OF SOUTH DAKOTA }
County of Minnehaha } ss

On this 15th day of August, 2014, before me, appeared

Paul T. Bruflat to me personally known, being by me sworn, and did say that he is the aforesaid officer of WESTERN SURETY COMPANY, and that the seal affixed to said instrument is the corporate seal of said corporation, and that said instrument was signed and sealed on behalf of said corporation by authority of its Board of Directors, and said officer acknowledged said instrument to be the free act and deed of said corporation.



S. Petrik
Notary Public

My Commission Expires August 11, 2016

OATH OF OFFICE

I do solemnly swear (or affirm) that I will support, obey and defend the constitution of the United States, and the constitution of the state of Wyoming; that I have not knowingly violated any law related to my election or appointment, or caused it to be done by others; and that I will discharge the duties of my office with fidelity.

Ann Rudoff

State of Wyoming }
County of Sweetwater } ss

This Oath of Office was subscribed and sworn to before me by Ann Rudoff
on this 28th day of October, 2014
My commission expires:

January 17, 2015
Theresa L. Riana
Notary Public, Wyoming

ACKNOWLEDGMENT OF PRINCIPAL

THE STATE OF WYOMING }
County of Sweetwater } ss

On this 28th day of October, 2014, before me, personally appeared

Ann Rudoff, to me known to be the person described in and who executed the foregoing instrument as Principal, and acknowledged that the same was executed as her free act and deed.

My commission expires
January 17, 2015
Theresa L. Riana
Notary Public, Wyoming



Wyoming



Western Surety Company

OFFICIAL BOND AND OATH

KNOW ALL PERSONS BY THESE PRESENTS:

Bond No. 53919818

That we Vivian Sheddin

of Granger, Wyoming, as Principal, and WESTERN SURETY COMPANY, a corporation duly licensed to do business in the State of Wyoming, as Surety, are held and firmly bound unto Town of Granger, the State of Wyoming, in the penal sum of Fifteen Thousand and 00/100 DOLLARS (\$ 15,000.00), to which payment well and truly to be made, we bind ourselves and our legal representatives, jointly and severally, firmly by these presents.

Dated this 1st day of August, 2014.

THE CONDITION OF THE ABOVE OBLIGATION IS SUCH, That whereas, the above bounden Principal was duly Appointed Elected to the office of Clerk/Treasurer in the Town of Granger, and State aforesaid for the term beginning November 17, 2014, and ending November 17, 2015.

NOW THEREFORE, If the above bounden Principal and his deputies shall faithfully, honestly and impartially perform all the duties of his said office of Clerk/Treasurer as is or may be prescribed by law, and shall with all reasonable skill, diligence, good faith and honesty safely keep and be responsible for all funds coming into the hands of such officer by virtue of his office; and pay over without delay to the person or persons authorized by law to receive the same, all moneys which may come into his hands by virtue of his said office; and shall well and truly deliver to his successor in office, or such other person or persons as are authorized by law to receive the same, all moneys, books, papers and things of every kind and nature held by him as such officer, the above obligation shall be void, otherwise to remain in full force and effect.



Vivian Sheddin
Principal

WESTERN SURETY COMPANY
By Paul T. Bruffat
Paul T. Bruffat, Senior Vice President



Western Surety Company

RIDER

It is hereby mutually agreed and understood by and between the Principal and Western Surety Company, that instead of as originally written:

The Principal's name has been changed to read:

Description of Bond is amended to read
"Appointed" in lieu of "Elected"

Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, limits or conditions of the _____ bond _____, except as hereinabove set forth.



This Rider becomes effective on the 17th day of November, 2014 at _____ o'clock a.m., standard time.

Attached to and forming part of _____ bond No. 53919818
issued by WESTERN SURETY COMPANY of Sioux Falls, South Dakota, to
Vivian Shedden

Signed this 17th day of November, 2014

WESTERN SURETY COMPANY

By Shedden, T. P.

BOARD OF COUNTY COMMISSIONERS MEETING REQUEST FORM

Date Requested: 12-2-14	Name & Title of Presenter: Commissioners
Department or Organization:	Contact Phone & E-mail: 307-872-3890
Exact Wording for Agenda: Resolution Increasing the Salary of Chief Deputies	Preference of Placement on Agenda & Amount of Time Requested for Presentation: 5 min
Will there be Handouts? (If yes, include with meeting request form) Yes	Will handouts require SIGNATURES: yes
Additional Information: Resolution was prepared by Human Resource Director Garry McLean	

- All requests to be added to the agenda will need to be submitted in writing on the "Meeting Request Form" by Wednesday at 12:00 p.m. prior to the scheduled meeting and returned in person or electronically to Clerk Sally Shoemaker at: shoemakers@sweet.wy.us
- All handouts are also due by Wednesday at 12:00 p.m. prior to the scheduled meeting date. Handouts may be submitted to Clerk Sally Shoemaker either in person or electronically. *****If your handout is not accompanied with the request to be added to the agenda, your request will be dismissed and you may reschedule for the next meeting provided the handout(s) are received.*****
- Any documents requiring **Board Action or signature** are considered agenda items and need to be requested in the same manner.
- All **original** documents requesting action or signature must be submitted to Deputy County Clerk Vickie Eastin. However, a **copy** must be submitted to Sally Shoemaker for distribution of the packet and retention.
- As always, if you are unable to attend the meeting after being placed onto an agenda, please send a representative in your place or your item will be rescheduled.
- In order to determine placement on the agenda, please review the county website (www.sweet.wy.us/commissioner) on Thursday afternoon.
- If a request to be placed on an agenda is received **AFTER** the deadline, you will be considered for the next meeting date.
- No handout will be received during a meeting in session.

SWEETWATER C·O·U·N·T·Y

RESOLUTION NO. 12-14-CC-03
INCREASING THE SALARY OF CHIEF DEPUTIES IN THE RESPECTIVE
OFFICES OF THE COUNTY CLERK, TREASURER, ASSESSOR AND CLERK OF
DISTRICT COURT

WHEREAS, The Sweetwater County Board of County Commissioners, as part of the board's statutory and budgetary responsibilities, sets the salaries for elected officials, deputies and county employees; and,

WHEREAS, the Sweetwater County Board of County Commissioners fixed the salaries of the eligible County Elected Officials in the office of the County Sheriff, Attorney, Clerk, Treasurer, Assessor, and Clerk of District Court at \$100,000, effective January 1, 2015; and,

WHEREAS, the Chief Deputies in the respective offices of the County Clerk, Treasurer, Assessor, and Clerk of District Court last received a salary adjustment in January 1, 2007;

NOW THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF THE COUNTY OF SWEETWATER, STATE OF WYOMING:

That the annual salary for the Chief Deputies in the respective offices of the County Clerk, Treasurer, Assessor, and Clerk of District Court be increased by 33.33 % from their current annual rate of \$63,750 to \$85,000, effective January 1, 2015.

Passed and approved this 2nd day of December, 2014.

THE BOARD OF COUNTY COMMISSIONERS
OF SWEETWATER COUNTY, WYOMING

Wally J. Johnson, Commission Chairman

Gary Bailiff, Commissioner

John K. Kolb, Commissioner

ATTEST:

Don Van Matre, Commissioner

Steven Dale Davis, County Clerk

Reid O. West, Commissioner

Sweetwater County Board Appointments

EVENTS COMPLEX- Effective 1-1-15

5 YEAR TERM

Paul Zancanella's Term expires 1-1-15

ELIGIBLE FOR RE-APPOINTMENT

Paul Zancanella

Yes	No

New Applicant(s)-

Daniel Frink

James Landwehr

Roger Torgersen

Yes	No

November 25, 2014

Sweetwater County Commissioners
80 West Flaming Gorge Way
Green River, Wyoming 82935

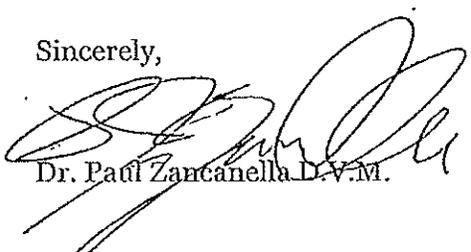
Dear Commissioners:

As you are aware I currently serve on the Sweetwater Events Complex Board of Trustees. My term expires in January 2015. Please accept this letter as a formal request to be reappointed for an additional term to the Events Complex Board.

I consider the Sweetwater Events Complex an important and integral part of the recreational assets made available to the citizens of Sweetwater County and all of Southern Wyoming. I have enjoyed the opportunity to be part of the Events Complex during a time of increased public usage and growth.

Your consideration of my reappointment would be greatly appreciated.

Sincerely,



Dr. Paul Zancanella D.V.M.

1861 Yellowstone Road
Rock Springs, WY 82901

RECEIVED

MAR 22 2013

SWEETWATER COUNTY COMMISSIONER'S OFFICE

Application For Appointment To A County Board

Message From the County Commissioners: The Sweetwater County Board of County Commissioners believes that all citizens have the right to participate in making Sweetwater County a better place. By being appointed to County Boards, citizens are able to make valuable decisions that positively impact the quality of life in Sweetwater County. The County Commissioners may make appointments at any time. By submitting this application you are expressing your interest in being part of the solutions for Sweetwater County. Your application will remain active for two (2) years. Below is a list of County Boards appointed by the Commission. Please indicate in which board you are interested in serving. All board positions are unpaid, volunteer positions.

I wish to volunteer to serve on the following County Board (s) (Select two (2) only):

Joint Powers Boards

- Airport Board
- Upper Green River Joint Powers Water Board
- Joint Powers Water Board

District Boards

- Solid Waste Disposal District No. 1 (Rock Springs)
- Eden Valley Solid Waste Disposal District
- Solid Waste Disposal District No. 2 (Balroll-Wamsutter)
- District Board of Health

County Agency Boards

- Events Complex (Fair Board)
- Library Board
- Museum Board
- Memorial Hospital Board
- Parks and Recreation Board
- Mental Health Board (Southwest Counseling)
- Other _____
- Other _____

Other County Appointed Boards

- Planning and Zoning Commission
- Sweetwater Transit Authority Resources (STAR)
- Community Fine Arts Center
- Joint Travel and Tourism Board
- Predatory Animal Board
- Miners Hospital Board

The specific skills, knowledge and experience I bring to this Board are: Nebraska Horse 4-H Judge
Many years of Horse Show Management Experience, Horse Trainer,
Nebraska Cattle 4-H Programs as a youth,
Hospital/Clinic Administrator, 20 years Army Captain Retired.

- I am willing to attend any required orientation and training sessions. YES NO
- I have a family member (s) working in this organization. YES NO
- I am willing to sign the Conflict of Interest Disclosure Statement YES NO
- I understand this is a volunteer role, with no salary or other considerations. YES NO

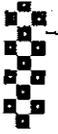
APPLICANT CONTACT INFORMATION

Name: Daniel D. Frink (Dan)
 Address: 647 Granite
 City, State: Rock Springs, WY 82901
 Phone: 308-293-4556
 E-mail: danfrinke@hotmail.com

APPLICANT SIGNATURE:

Daniel D Frink Date: 3-20-2013

Please Return Application To:
 Sally Shoemaker, Clerk
 80 West Flaming Gorge Way, Suite 109
 Green River, WY 82935
 Phone: 307-872-3897 or fax 307-872-3992
 E-mail: shoemakers@sweet.wy.us



RECEIVED

JAN 02 2013

SWEETWATER COUNTY COMMISSIONER'S OFFICE

Application For Appointment To A County Board

Message From the County Commissioners: The Sweetwater County Board of County Commissioners believes that all citizens have the right to participate in making Sweetwater County a better place...

I wish to volunteer to serve on the following County Board (s) (Select two (2) only):

Joint Powers Boards

- Airport Board
Upper Green River Joint Powers Water Board
Joint Powers Water Board

District Boards

- Solid Waste Disposal District No. 1 (Rock Springs)
Eden Valley Solid Waste Disposal District
Solid Waste Disposal District No. 2 (Bairoil-Wamsutter)
District Board of Health

Other County Appointed Boards

- Planning and Zoning Commission
Sweetwater Transit Authority Resources (STAR)
Community Fine Arts Center

County Agency Boards

- Events Complex (Fair Board)
Library Board
Museum Board
Memorial Hospital Board
Parks and Recreation Board
Mental Health Board (Southwest Counseling)
Other
Other

The specific skills, knowledge and experience I bring to this Board are: I have been in and around rodeo for over 30 years, I have my PACT & my PBRB Cards I ride on the senior circuit I own my own ranch here in Rock Springs. I would like to be able to help and be more involved.

I am willing to attend any required orientation and training sessions. YES [X] NO []
I have a family member (s) working in this organization. YES [] NO [X]
I am willing to sign the Conflict of Interest Disclosure Statement YES [X] NO []
I understand this is a volunteer role, with no salary or other considerations. YES [X] NO []

APPLICANT CONTACT INFORMATION

Name: JAMES Landwehr
Address: 506 yellowstone Rd
City, State: Rock Springs, WY 82901
Phone: 307-220-0916
E-mail: circle JLRanch @ Yahoo.com

APPLICANT SIGNATURE:

James Landwehr Date: 12-31-12

Please Return Application To: Sally Shoemaker, Clerk 80 West Flaming Gorge Way, Suite 109 Green River, WY 82935 Phone: 307-872-3997 or fax 307-872-3992 E-mail: shoemakers@sweet.wy.us

RECEIVED

NOV 10 2014

SWEETWATER COUNTY
COMMISSIONER'S OFFICE

Application for Board Appointment to a Sweetwater County Board

Message from the County Commissioners: The Sweetwater County Board of County Commissioners believes that all citizens have the right to participate in making Sweetwater County a better place. By being appointed to County Boards, citizens are able to make valuable decisions that positively impact the quality of life in Sweetwater County. The County Commissioners may make appointments at any time. By submitting this application you are expressing your interest in being part of the solutions for Sweetwater County. Your application will remain active for two (2) years. Below is a list of County Boards appointed by the Commission. Please indicate in which board you are interested in serving. All board positions are unpaid, volunteer positions.

I wish to volunteer to serve on the following County Board (s): ****Select two (2) only****

Joint Powers Boards

- Airport Board
- Upper Green River Joint Powers Water Board
- Joint Powers Water Board
- Community Juvenile Services Board

District Boards

- Solid Waste Disposal District No. 1 (Rock Springs)
- Eden Valley Solid Waste Disposal District
- Solid Waste Disposal District No. 2 (Bairoil/Wamsutter)
- District Board of Health

Other County Appointed Boards

- Planning & Zoning Commission
- Sweetwater Transit Authority Resources (STAR)
- Community Fine Arts Center

County Agency Boards

- Events Complex (Fair Board)
- Library Board
- Museum Board
- Memorial Hospital Board
- Parks & Recreation Board
- Southwest Counseling
- Other
- Other
- Other

- Joint Travel & Tourism Board
- Predatory Animal Board
- Miners Hospital Board

The specific skills, knowledge, and experience I bring to this Board are: (attach a separate page)

I am willing to attend any required orientation and training session	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have a family member(s) working in this organization	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I am willing to sign the Conflict of Interest Disclosure Statement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I understand this is a volunteer role, with no salary or other considerations	<input type="checkbox"/> Yes	<input type="checkbox"/> No

APPLICANT CONTACT INFORMATION:

NAME: ROBERT TORGERSEN
 ADDRESS: 379 yellowstone rd
Rock Springs WY 82901
 Phone: 307 350-6605 Cell
 E-mail: 307-382-8166 Home

Signature: [Handwritten Signature]

Please Return Application to:
 Sally Shoemaker, Clerk
 80 W Flaming Gorge Way, Suite 109
 Green River, WY 82935
 Phone: 307-872-3897 or fax 307-872-3992
 E-mail: shoemakers@sweet.wy.us

November 7, 2014

Sweetwater County Commissioners
80 West Flaming Gorge Way
Green River, Wyoming 82935

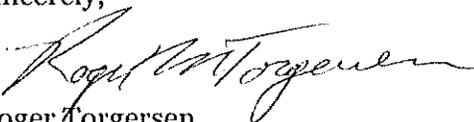
Dear Commissioners:

Please accept this letter as a formal request to be appointed to the Events Complex Board. I am a local business owner and work within the gas and oil industry.

I consider the Sweetwater Events Complex an important and integral part of the recreational assets made available to the citizens of Sweetwater County and all of Southern Wyoming. I have been an Events Complex volunteer for a number of years and have enjoyed the opportunity to be part of the Events Complex during a time of increased public usage and growth.

Your consideration of my appointment would be greatly appreciated.

Sincerely,


Roger Torgersen

379 Yellowstone Road
Rock Springs, WY 82901

Sweetwater County Board Appointments

Recreation Board- Effective immediately

to fill an unexpired term through 7-1-17

due to resignation of Allan Wilson effective 11-19-14

ELIGIBLE FOR RE-APPOINTMENT

n/a

Yes	No

New Applicant(s)-

Jason Faigl

Tim Sheehan

Grant Yaklich

Yes	No

RECEIVED

NOV 19 2014

SWEETWATER COUNTY
COMMISSIONER'S OFFICE

Allan Wilson
66 South 4th West
Green River, WY 82935
November 19th, 2014

Dear Sweetwater County Recreation Board:

Please accept this as official notice of my resignation. As you know, over the last three months, I have had many changes in my life. It is clear to me that I cannot give the Recreation Board my best to help. Therefore, I feel that resigning is the best option for me.

My last day will be [November 19, 2014]

Sincerely,

A handwritten signature in black ink that reads "Allan Wilson". The signature is written in a cursive style with a long horizontal flourish at the end.

Allan Wilson
Treasurer

RECEIVED

JUN 17 2014

SWEETWATER COUNTY
COMMISSIONER'S OFFICE

Application for Board Appointment to a Sweetwater County Board

Message from the County Commissioners: The Sweetwater County Board of County Commissioners believes that all citizens have the right to participate in making Sweetwater County a better place. By being appointed to County Boards, citizens are able to make valuable decisions that positively impact the quality of life in Sweetwater County. The County Commissioners may make appointments at any time. By submitting this application you are expressing your interest in being part of the solutions for Sweetwater County. Your application will remain active for two (2) years. Below is a list of County Boards appointed by the Commission. Please indicate in which board you are interested in serving. All board positions are unpaid, volunteer positions.

I wish to volunteer to serve on the following County Board (s): ****Select two (2) only****

Joint Powers Boards

- Airport Board
- Upper Green River Joint Powers Water Board
- Joint Powers Water Board
- Community Juvenile Services Board

District Boards

- Solid Waste Disposal District No. 1 (Rock Springs)
- Eden Valley Solid Waste Disposal District
- Solid Waste Disposal District No. 2 (Bairoil/Wamsutter)
- District Board of Health

County Agency Boards

- Events Complex (Fair Board)
- Library Board
- Museum Board
- Memorial Hospital Board
- Parks & Recreation Board
- Southwest Counseling
- Other
- Other
- Other

Other County Appointed Boards

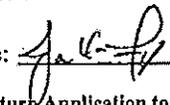
- Planning & Zoning Commission
- Sweetwater Transit Authority Resources (STAR)
- Community Fine Arts Center
- Joint Travel & Tourism Board
- Predatory Animal Board
- Miners Hospital Board

The specific skills, knowledge, and experience I bring to this Board are: (attach a separate page)

I am willing to attend any required orientation and training session	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have a family member(s) working in this organization	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I am willing to sign the Conflict of Interest Disclosure Statement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I understand this is a volunteer role, with no salary or other considerations	<input type="checkbox"/> Yes	<input type="checkbox"/> No

APPLICANT CONTACT INFORMATION:

NAME: Jason Faigl
ADDRESS: 234 Flagstone Dr.
Rock Springs, WY. 82901
Phone: 307-371-9991
E-mail: jfaigl@mtncom.net

Signature: 
Please Return Application to:
Sally Shoemaker, Clerk -
80 W Flaming Gorge Way, Suite 109
Green River, WY 82935
Phone: 307-872-3897 or fax 307-872-3992
E-mail: shoemakers@sweet.wy.us

Jason K. Faigl
234 Flagstone Dr.
Rock Springs, WY. 82901

June 11th, 2014

Board of County Commissioners
Sweetwater County Wyoming
80 West Flaming Gorge Way, Suite 109
Green River, WY. 82935

Dear Mr. Chairman and Sweetwater County Board of Commissioners,

I write to ask for your consideration for appointment to fill the vacancy on the Sweetwater County Parks and Recreation Board. I was born and raised in Sweetwater County, and believe this is a wonderful place to raise our kids, and make a honest living. I am presently a Branch Manager of Mountainland Supply Company in Rock Springs. I have been involved with Plumbing, HVAC, Irrigation, and Waterworks industry for 17 years. I graduated from Rock Springs High School in 1994, followed by graduating from Western Wyoming Community College in 1997.

Sweetwater County offers a endless supply of recreational opportunities that is a privledge to have in today. I would enjoy recreating our local community in various ways from parks, to facilities, to the great outdoors. I feel my addition to the board would bring new ideas and plans to the county.

Thank you for your consideration.

Sincerely,

Jason Faigl

RECEIVED

AUG 28 2013

SWEETWATER COUNTY COMMISSIONER'S OFFICE

Application For Appointment To A County Board

Message From the County Commissioners: The Sweetwater County Board of County Commissioners believes that all citizens have the right to participate in making Sweetwater County a better place. By being appointed to County Boards, citizens are able to make valuable decisions that positively impact the quality of life in Sweetwater County. The County Commissioners may make appointments at any time. By submitting this application you are expressing your interest in being part of the solutions for Sweetwater County. Your application will remain active for two (2) years. Below is a list of County Boards appointed by the Commission. Please indicate in which board you are interested in serving. All board positions are unpaid, volunteer positions.

I wish to volunteer to serve on the following County Board (s) (Select two (2) only):

Joint Powers Boards

- Airport Board
- Upper Green River Joint Powers Water Board
- Joint Powers Water Board

District Boards

- Solid Waste Disposal District No. 1 (Rock Springs)
- Eden Valley Solid Waste Disposal District
- Solid Waste Disposal District No. 2 (Bairoil-Wamsutter)
- District Board of Health

County Agency Boards

- Events Complex (Fair Board)
- Library Board
- Museum Board
- Memorial Hospital Board
- Parks and Recreation Board
- Mental Health Board (Southwest Counseling)
- Other _____
- Other _____

Other County Appointed Boards

- Planning and Zoning Commission
- Sweetwater Transit Authority Resources (STAR)
- Community Fine Arts Center
- Joint Travel and Tourism Board
- Predatory Animal Board
- Miners Hospital Board

The specific skills, knowledge and experience I bring to this Board are: LEADERSHIP FROM A GAS UTILITY BUSINESS, WILLINGNESS TO HELP AND BE INVOLVED

- I am willing to attend any required orientation and training sessions. YES NO
- I have a family member (s) working in this organization. YES NO
- I am willing to sign the Conflict of Interest Disclosure Statement YES NO
- I understand this is a volunteer role, with no salary or other considerations. YES NO

APPLICANT CONTACT INFORMATION

Name: Tim SHEEHAN (Sheehan)
 Address: 249 CHARDINWAY LONG
 City, State: Rock Springs Wyo. 82901
 Phone: 307 350 0545
 E-mail: TIM.SHEEHAN@BUNGSTAR.COM

APPLICANT SIGNATURE:

T. V. She Date: 8/28/13

Please Return Application To:
 Sally Shoemaker, Clerk
 80 West Flaming Gorge Way, Suite 109
 Green River, WY 82935
 Phone: 307-872-3897 or fax 307-872-3992
 E-mail: shoemakers@sweet.wy.us

RECEIVED

JUL 23 2013

SWEETWATER COUNTY COMMISSIONER'S OFFICE

Application For Appointment To A County Board

Message From the County Commissioners: The Sweetwater County Board of County Commissioners believes that all citizens have the right to participate in making Sweetwater County a better place.

I wish to volunteer to serve on the following County Board (s) (Select two (2) only):

Joint Powers Boards

- Airport Board
Upper Green River Joint Powers Water Board
Joint Powers Water Board

District Boards

- Solid Waste Disposal District No. 1 (Rock Springs)
Eden Valley Solid Waste Disposal District
Solid Waste Disposal District No. 2 (Bairoil-Wamsutter)
District Board of Health

County Agency Boards

- Events Complex (Fair Board)
Library Board
Museum Board
Memorial Hospital Board
Parks and Recreation Board
Mental Health Board (Southwest Counseling)
Other
Other

Other County Appointed Boards

- Planning and Zoning Commission
Sweetwater Transit Authority Resources (STAR)
Community Fine Arts Center
Joint Travel and Tourism Board
Predatory Animal Board
Miners Hospital Board

The specific skills, knowledge and experience I bring to this Board are: 30 years exp Turf Industry - Past President - Rocky Mountain Regional Turf Course Assn.

- I am willing to attend any required orientation and training sessions. YES [X] NO []
I have a family member (s) working in this organization. YES [] NO [X]
I am willing to sign the Conflict of Interest Disclosure Statement YES [X] NO []
I understand this is a volunteer role, with no salary or other considerations. YES [X] NO []

APPLICANT CONTACT INFORMATION

Name: Grant A. Yabluch
Address: 1325 Chebbon Dr
City, State: Rock Springs WY 82901
Phone: 307-350-1414
E-mail: geyabluch@gmail.com

APPLICANT SIGNATURE:

[Signature] Date: 7/25/13

Please Return Application To:
Sally Shoemaker, Clerk
80 West Flaming Gorge Way, Suite 109
Green River, WY 82935
Phone: 307-872-3897 or fax 307-872-3992
E-mail: shoemakers@sweet.wy.us

Ten Mile Water & Sewer District
3 appointments (2 Year Term)

Due to Ten Mile Water & Sewer District not having their proclamation published for the filing period and election for the Ten Mile Water & Sewer District Candidates, the District does not have a quorum (3 vacancies)

Per State Statute W.S 22-29-202 SWCO Commission must appoint Directors

New Applicant(s)-

Jason Clemens
Ann Etcheverry
Gordon Scott
Michael Tacke

Yes	No

RECEIVED

OCT 28 2014

SWEETWATER COUNTY
COMMISSIONER'S OFFICE

Dear Sweetwater County Commission,

Please take notice that on November 15, 2014, there will be a vacancy in a majority of the offices of director for the Ten Mile Water and Sewer Districts, Sweetwater County, Wyoming. W.S. §22-29-118. This letter is notice of such anticipated vacancy, pursuant to W.S. §22-29-202, and a request that the Commission fill the three vacancies.

As the Commission is aware, it is difficult for small districts like ours to find and retain directors. Fortunately, after several months of appealing to our members, we are lucky to have had four individuals express interest in serving the District. The contact information for these four individuals follows:

Mike Tacke
25 Jackman Access Rd
Rock Springs, WY 82901
Daytime: 362-5975
Evening: 354-8981

Gordon Scott
16 Stassinos Ranch Rd
Rock Springs, WY 82901
307-780-7563

Ann Etcheverry
10 Stassinos Ranch Rd
Rock Springs, WY 82901
307-389-7282

Jason Clemens
525 Evelyn Rd.
Rock Springs, WY 82901
307-752-6250

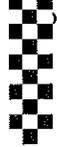
Sincerely,

Lynette Sibley, President

Ten Mile Water & Sewer District

*382-5138
371-6551 - cell*

*Kyle Graham
371-7589*



RECEIVED

NOV 18 2011

SWEETWATER COUNTY COMMISSIONER'S OFFICE

Application for Board Appointment to a Sweetwater County Board

Message from the County Commissioners: The Sweetwater County Board of County Commissioners believes that all citizens have the right to participate in making Sweetwater County a better place. By being appointed to County Boards, citizens are able to make valuable decisions that positively impact the quality of life in Sweetwater County. The County Commissioners may make appointments at any time. By submitting this application you are expressing your interest in being part of the solutions for Sweetwater County. Your application will remain active for two (2) years. Below is a list of County Boards appointed by the Commission. Please indicate in which board you are interested in serving. All board positions are unpaid, volunteer positions.

I wish to volunteer to serve on the following County Board (s): ****Select two (2) only****

Joint Powers Boards

- Airport Board
- Upper Green River Joint Powers Water Board
- Joint Powers Water Board
- Community Juvenile Services Board

District Boards

- Solid Waste Disposal District No. 1 (Rock Springs)
- Eden Valley Solid Waste Disposal District
- Solid Waste Disposal District No. 2 (Bairoil/Wamsutter)
- District Board of Health

County Agency Boards

- Events Complex (Fair Board)
- Library Board
- Museum Board
- Memorial Hospital Board
- Parks & Recreation Board
- Southwest Counseling
- Other *Ten Mile Water Board*
- Other
- Other

Other County Appointed Boards

- Planning & Zoning Commission
- Sweetwater Transit Authority Resources (STAR)
- Community Fine Arts Center
- Joint Travel & Tourism Board
- Predatory Animal Board
- Miners Hospital Board

The specific skills, knowledge, and experience I bring to this Board are: (attach a separate page)

- | | | |
|---|---|--|
| I am willing to attend any required orientation and training session | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| I have a family member(s) working in this organization | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| I am willing to sign the Conflict of Interest Disclosure Statement | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| I understand this is a volunteer role, with no salary or other considerations | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |

APPLICANT CONTACT INFORMATION:

NAME: Jason Clemens

ADDRESS: 525 Evelyn Rd
Rock Springs WY 82901

Phone: 307 752-6250

E-mail: bigcamclemens@hotmail.com

Signature:

Please Return Application to:
 Sally Shoemaker, Clerk
 80 W Flaming Gorge Way, Suite 109
 Green River, WY 82935
 Phone: 307-872-3897 or fax 307-872-3992
 E-mail: shoemakers@sweet.wy.us

RECEIVED

NOV 14 2014

SWEETWATER COUNTY COMMISSIONER'S OFFICE

Application for Board Appointment to a Sweetwater County Board

Message from the County Commissioners: The Sweetwater County Board of County Commissioners believes that all citizens have the right to participate in making Sweetwater County a better place. By being appointed to County Boards, citizens are able to make valuable decisions that positively impact the quality of life in Sweetwater County. The County Commissioners may make appointments at any time. By submitting this application you are expressing your interest in being part of the solutions for Sweetwater County. Your application will remain active for two (2) years. Below is a list of County Boards appointed by the Commission. Please indicate in which board you are interested in serving. All board positions are unpaid, volunteer positions.

I wish to volunteer to serve on the following County Board (s): ****Select two (2) only****

Joint Powers Boards

- Airport Board
- Upper Green River Joint Powers Water Board
- Joint Powers Water Board
- Community Juvenile Services Board

District Boards

- Solid Waste Disposal District No. 1 (Rock Springs)
- Eden Valley Solid Waste Disposal District
- Solid Waste Disposal District No. 2 (Bairoil/Wamsutter)
- District Board of Health

Other County Appointed Boards

- Planning & Zoning Commission
- Sweetwater Transit Authority Resources (STAR)
- Community Fine Arts Center

County Agency Boards

- Events Complex (Fair Board)
- Library Board
- Museum Board
- Memorial Hospital Board
- Parks & Recreation Board
- Southwest Counseling
- Other Ten Mile Water Board
- Other
- Other

The specific skills, knowledge, and experience I bring to this Board are: (attach a separate page)

- | | | |
|---|---|--|
| I am willing to attend any required orientation and training session | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| I have a family member(s) working in this organization | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| I am willing to sign the Conflict of Interest Disclosure Statement | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| I understand this is a volunteer role, with no salary or other considerations | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |

APPLICANT CONTACT INFORMATION:

NAME: Ann Etcheverry

ADDRESS: 10 Stassinis Ranch Road
Rock Springs, WY 82901

Phone: 307-389-7282

E-mail: ann.etccheverry@gmail.com

Signature: 

Please Return Application to:
 Sally Shoemaker, Clerk
 80 W Flaming Gorge Way, Suite 109
 Green River, WY 82935
 Phone: 307-872-3897 or fax 307-872-3992
 E-mail: shoemakers@sweet.wy.us

RECEIVED
 NOV 13 2014
 SWEETWATER COUNTY
 COMMISSIONERS OFFICE

Application for Board Appointment to a Sweetwater County Board

Message from the County Commissioners: The Sweetwater County Board of County Commissioners believes that all citizens have the right to participate in making Sweetwater County a better place. By being appointed to County Boards, citizens are able to make valuable decisions that positively impact the quality of life in Sweetwater County. The County Commissioners may make appointments at any time. By submitting this application you are expressing your interest in being part of the solutions for Sweetwater County. Your application will remain active for two (2) years. Below is a list of County Boards appointed by the Commission. Please indicate in which board you are interested in serving. All board positions are unpaid, volunteer positions.

I wish to volunteer to serve on the following County Board (s): ****Select two (2) only****

Joint Powers Boards

- Airport Board
- Upper Green River Joint Powers Water Board
- Joint Powers Water Board
- Community Juvenile Services Board

District Boards

- Solid Waste Disposal District No. 1 (Rock Springs)
- Eden Valley Solid Waste Disposal District
- Solid Waste Disposal District No. 2 (Bairoil/Wamsutter)
- District Board of Health

County Agency Boards

- Events Complex (Fair Board)
- Library Board
- Museum Board
- Memorial Hospital Board
- Parks & Recreation Board
- Southwest Counseling
- Other *Ten Mile Water*
- Other
- Other

Other County Appointed Boards

- Planning & Zoning Commission
- Sweetwater Transit Authority Resources (STAR)
- Community Fine Arts Center
- Joint Travel & Tourism Board
- Predatory Animal Board
- Miners Hospital Board

The specific skills, knowledge, and experience I bring to this Board are: (attach a separate page)

- | | | |
|---|---|--|
| I am willing to attend any required orientation and training session | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| I have a family member(s) working in this organization | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| I am willing to sign the Conflict of Interest Disclosure Statement | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| I understand this is a volunteer role, with no salary or other considerations | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |

APPLICANT CONTACT INFORMATION:

NAME: Gordon Scott

Signature: Gordon Scott

ADDRESS: 16 Stassinias Ranch Rd
Rock Springs, WY 82901

Please Return Application to:
 Sally Shoemaker, Clerk
 80 W Flaming Gorge Way, Suite 109
 Green River, WY 82935
 Phone: 307-872-3897 or fax 307-872-3992
 E-mail: shoemakers@sweet.wy.us

Phone: 307-780-7563

E-mail: scottg-g@hotmail.com

RECEIVED

SEP 17 2014

SWEETWATER COUNTY
COMMISSIONER'S OFFICE

Application for Board Appointment to a Sweetwater County Board

Message from the County Commissioners: The Sweetwater County Board of County Commissioners believes that all citizens have the right to participate in making Sweetwater County a better place. By being appointed to County Boards, citizens are able to make valuable decisions that positively impact the quality of life in Sweetwater County. The County Commissioners may make appointments at any time. By submitting this application you are expressing your interest in being part of the solutions for Sweetwater County. Your application will remain active for two (2) years. Below is a list of County Boards appointed by the Commission. Please indicate in which board you are interested in serving. All board positions are unpaid, volunteer positions.

I wish to volunteer to serve on the following County Board (s): ****Select two (2) only****

Joint Powers Boards

- Airport Board
- Upper Green River Joint Powers Water Board
- Joint Powers Water Board
- Community Juvenile Services Board

District Boards

- Solid Waste Disposal District No. 1 (Rock Springs)
- Eden Valley Solid Waste Disposal District
- Solid Waste Disposal District No. 2 (Bairoil/Wamsutter)
- District Board of Health

County Agency Boards

- Events Complex (Fair Board)
- Library Board
- Museum Board
- Memorial Hospital Board
- Parks & Recreation Board
- Southwest Counseling
- Other 10 Mile Water & Sewer
- Other
- Other

Other County Appointed Boards

- Planning & Zoning Commission
- Sweetwater Transit Authority Resources (STAR)
- Community Fine Arts Center
- Joint Travel & Tourism Board
- Predatory Animal Board
- Miners Hospital Board

The specific skills, knowledge, and experience I bring to this Board are: (attach a separate page)

- | | | |
|---|---|--|
| I am willing to attend any required orientation and training session | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| I have a family member(s) working in this organization | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| I am willing to sign the Conflict of Interest Disclosure Statement | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| I understand this is a volunteer role, with no salary or other considerations | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |

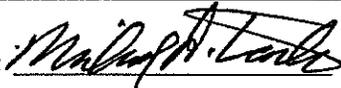
APPLICANT CONTACT INFORMATION:

NAME: Michael D. Tacke

ADDRESS: 25 Jackman Access Rd.
Rock Springs, WY 82901

Phone: 307-354-8981

E-mail: mdtacke@outlook.com

Signature: 

Please Return Application to:
 Sally Shoemaker, Clerk
 80 W Flaming Gorge Way, Suite 109
 Green River, WY 82935
 Phone: 307-872-3897 or fax 307-872-3992
 E-mail: shoemakers@sweet.wy.us

Michael D. Tacke
25 Jackman Access Road
Rock Springs, Wyoming 82901

November 17, 2014

Sally Shoemaker, Clerk
80W Flaming Gorge Way, Suite 109
Green River, WY 82935

To whom it may concern:

The application asks that I list "The specific skills, knowledge, and experience I bring to this Board". Hmmmm.

As for skills, I have absolutely none in the area of sitting on boards, although I do know that such gatherings require that the participants adhere to some sort of parliamentary procedure for the sake of maintaining order. I suspect that "Robert's Rules of Order" would be the guide for this procedure. My public speaking skills are non-existent. However, I believe most people are able to understand my meaning when I speak, lack of eloquence notwithstanding.

As I understand it, the function of the Board for Ten Mile is to direct the successful operation of the organization and infrastructure for an existing potable water delivery system, and a potential future sewer system in the unincorporated area located north of the City of Rock Springs of which I am currently a resident. I do have an extensive working knowledge of water delivery systems from an approximate decade of working with agricultural irrigation systems. I further understand that potable systems require much more stringent precautions concerning quality of water delivered for human consumption than an agricultural system. So I guess one could say that I have a basic "nuts and bolts" understanding of the infrastructure.

The organizational side of the Ten Mile District is something I would have to be educated on. I initially thought that the entity was self-supported, but realized that could not be entirely true when I saw on my Sweetwater County Property Tax Statement a line charge of \$140.80 for Ten Mile Water and Sewer District. As the founder, owner, President and CEO of a local business (Independence Enterprises, Inc.) for the last twelve years, I have an intimate understanding of the non-Marxist concept that accounting books must balance. And by the way, a little cash reserve never hurts either.

"Skills, knowledge, and experience" are all well and good when evaluating someone for a position, but perhaps it is worth enquiring, "motivation". In my case, it is not complicated. As a customer of the District, it is obviously in my self-interest that the entity be successful. When I received a bill with a plea for participation enclosed, it occurred to me that it wouldn't be the first time in my life that I stepped forward when no one else seemed so inclined. Call it a character flaw. Having attended the next board meeting, I noticed that I was not entirely alone in this flaw. So, since I am probably the least qualified of any who have expressed their willingness to fill the position, please feel free to select any other applicant ahead of myself with no fear of injuring my feelings. Consider me a last resort.

Sincerely,



Michael D. Tacke

Sally Shoemaker

From: Michael Tacke <mdtacke@outlook.com>
Sent: Monday, November 17, 2014 11:22 AM
To: Sally Shoemaker
Cc: lynette@tenmilewater.org
Subject: Ten Mile Board application
Attachments: Fillable Application for Board Appointment to a County Board_si.pdf; 10 Mile - skills, knowledge, experience.pdf

Sally,

I am told that you are the one to send this to. You may note from the attachment listing my skills, I have no burning desire to be the chosen one. I do, however, have a sense of duty. Let the chips fall where they may.

Mike

Sally Shoemaker

From: Lynn <tanker42@msn.com>
Sent: Monday, November 17, 2014 9:48 PM
To: Sally Shoemaker
Subject: RE: Ten Mile info

Hi Sally, OK that sounds good. I do have one other person that has decided to put his name in to the commissioners as being interested in serving on the board. It is Dave Calvert. He was on the board prior to Kyle Graham. Kyle took his place when Dave's job changed to all evening hours and he was not able to make the meetings. He will be coming over to fill out an application and I will forward it on to you. I would highly recommend that he be appointed because he was a very fair minded person and knows alot about this district since he has been here since it was started.

I also faxed Ann Etcheverry's application to you as I got a copy of it via e-mail and she didn't say if she wanted me to forward it on or she had already done so.

According to Jon Aimone who talked with Mark Dedenbach, the advertisement in the newspaper is not going to be a requirement. I don't know anything further about that except that they talked and decided we didn't have to place the ad. If you have heard differently, please let me know.

Also, if I have forgotten something, I would appreciate a reminder and will get right on it.....Thanks for your help.....Lynn

From: shoemakers@sweet.wy.us
To: tanker42@msn.com
Subject: RE: Ten Mile info
Date: Mon, 17 Nov 2014 14:58:33 +0000

Hi Lynn.

You shouldn't have to bring anything because we requested all the materials (applications, copy of advertisement the term limits, etc) from you to place in the commissioners packet no later than noon on Tuesday, November 25, 2014

Thank you,

Sally

From: Lynn [mailto:tanker42@msn.com]
Sent: Saturday, November 15, 2014 11:03 PM
To: Sally Shoemaker
Subject: RE: Ten Mile info

Thanks, Sally and if there is anything I need to bring, could you please notify me of that too.....Lynn

From: shoemakers@sweet.wy.us
To: tanker42@msn.com
Subject: RE: Ten Mile info
Date: Fri, 14 Nov 2014 15:58:21 +0000
Hi Lynn.

This will be placed on the 12-2-14 BOCC meeting. Because the deadline to be placed on that agenda is noon on Tuesday, Nov. 25th, I won't have a time until after that date. For your convenience, please review the county website at www.sweet.wy.us (Board of County Commissioners Agenda) on Wednesday, Nov 26th to review placement time on the agenda.

Thank you,

Sally

From: Lynn [<mailto:tanker42@msn.com>]
Sent: Thursday, November 13, 2014 9:53 PM
To: Sally Shoemaker
Subject: RE: Ten Mile info

Sally, I will talk with Jon about coming and plan on being there myself. Any idea on what time of day our problem will be addressed? I faxed one application this evening for Gordon Scott. Ann Etcheverry will be doing hers tomorrow. Still have to catch up with Jason Clemens and Mike Tacke.

From: shoemakers@sweet.wy.us
To: tanker42@msn.com
Subject: RE: Ten Mile info
Date: Thu, 13 Nov 2014 15:11:48 +0000

That's a great question. Perhaps your attorney and the board chair would be a good idea to attend so that someone can explain what has transpired.

From: Lynn [<mailto:tanker42@msn.com>]
Sent: Wednesday, November 12, 2014 3:48 PM
To: Sally Shoemaker
Subject: RE: Ten Mile info

Sally, I will do my best to get you the applications. Regarding the legal advertisement, I called our attorney, Jon Aimone, and he was going to talk to Mark Dedenbach (sp) about that. I have not heard anything back from Jon yet.

Do you have any idea whether they want myself and Kyle Graham to attend the meeting or not. Have to take a day off and need to notify my boss as soon as I know anything.....Thanks.....Lynn

From: shoemakers@sweet.wy.us
To: tanker42@msn.com
Subject: RE: Ten Mile info
Date: Wed, 12 Nov 2014 22:25:28 +0000
Thank you, Lynn.

I will place the information you just provided in the Commissioner's packet along with the interested parties application. If you can have them submit to me by noon November 25th, we can get that placed in the December 2nd board meeting.

Also, did you happen to have a copy of the legal advertisement? I'd like to place that into their packet as well.

Thank you,

Sally Shoemaker

shoemakers@sweet.wy.us
307-872-3897 (office)
307-872-3992 (Fax)

From: Lynn [<mailto:tanker42@msn.com>]
Sent: Wednesday, November 12, 2014 3:16 PM
To: Sally Shoemaker
Subject: Ten Mile info

Hi Sally, Finally got an answer on the date the 3 board members were installed. It was December 8, 2010

The 3 board members whose terms expire are:

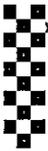
Ted Moosman Director at large
Glen Lehar President
Brian Stouffer Treasurer

They were all elected during our elections of November 4, 2010 but took the oath of office on December 8, 2010 during our regular monthly meeting.

I will take the applications to our meeting this evening and have the interested prospective board members fill them out then and fax them to you when I get home. Anne Etcheverry will not be there tonight and will handle her own application.

Also, during our last meeting, Mike Tacke, came and consented to volunteer for a board position; however, he wanted to be put last on the list.

Hope this is what you need. If there is anything else, please let me know.....Thanks.....Lynn Sibley



RECEIVED

NOV 17 2014

SWEETWATER COUNTY COMMISSIONER'S OFFICE

Application for Board Appointment to a Sweetwater County Board

Viewed from the County Commission. The Sweetwater County Board of County Commissioners believes that all citizens have the right to participate in making Sweetwater County a better place. By being appointed to County Boards, citizens are able to make valuable decisions that positively impact the quality of life in Sweetwater County. The County Commissioners may make appointments at any time. By submitting this application you are expressing your interest in being part of the solutions for Sweetwater County. Your application will remain active for two (2) years. Below is a list of County Boards appointed by the Commission. Please indicate in which board you are interested in serving. All board positions are unpaid, volunteer positions.

I wish to volunteer to serve on the following County Board (s): ****Select two (2) only****

Joint Powers Boards

- Airport Board
- Upper Green River Joint Powers Water Board
- Joint Powers Water Board
- Community Juvenile Services Board

District Boards

- Solid Waste Disposal District No. 1 (Rock Springs)
- Eden Valley Solid Waste Disposal District
- Solid Waste Disposal District No. 2 (Bairoil/Wamsutter)
- District Board of Health

Other County Appointed Boards

- Planning & Zoning Commission
- Sweetwater Transit Authority Resources (STAR)
- Community Fine Arts Center

County Agency Boards

- Events Complex (Fair Board)
- Library Board
- Museum Board
- Memorial Hospital Board
- Parks & Recreation Board
- Southwest Counseling
- Other Ten Mile Water Board
- Other
- Other

The specific skills, knowledge, and experience I bring to this Board are: (attach a separate page)

I am willing to attend any required orientation and training session	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
I have a family member(s) working in this organization	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
I am willing to sign the Conflict of Interest Disclosure Statement	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
I understand this is a volunteer role, with no salary or other considerations	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No

APPLICANT CONTACT INFORMATION:

NAME: Ann Etcheverry

ADDRESS: 10 Stassinis Ranch Road
Rock Springs, WY 82901

Phone: 307-389-7282

E-mail: ann.etcheverry@gmail.com

Signature: 

Please Return Application to:
 Sally Shoemaker, Clerk
 80 W Flaming Gorge Way, Suite 109
 Green River, WY 82935
 Phone: 307-872-3897 or fax 307-872-3992
 E-mail: shoemakers@sweet.wy.us

BOARD OF COUNTY COMMISSIONERS MEETING REQUEST FORM

Date Requested: December 2, 2014	Name & Title of Presenter: County Clerk Dale Davis
Department or Organization: County Clerk's office	Contact Phone & E-mail: 307-872-3765 davisd@sweet.wy.us
Exact Wording for Agenda: Resolution to Approve Additional Holidays for County Employees and County Offices to be Closed	Preference of Placement on Agenda & Amount of Time Requested for Presentation: >5 Mins Action Item
Will there be Handouts? (If yes, include with meeting request form)	Will handouts require SIGNATURES:
Additional Information:	

- All requests to be added to the agenda will need to be submitted in writing on the "Meeting Request Form" by Wednesday at 12:00 p.m. prior to the scheduled meeting and returned in person or electronically to Clerk Sally Shoemaker at: shoemakers@sweet.wy.us
- All handouts are also due by Wednesday at 12:00 p.m. prior to the scheduled meeting date. Handouts may be submitted to Clerk Sally Shoemaker either in person or electronically. *****If your handout is not accompanied with the request to be added to the agenda, your request will be dismissed and you may reschedule for the next meeting provided the handout(s) are received.*****
- Any documents requiring **Board Action or signature** are considered agenda items and need to be requested in the same manner.
- All **original** documents requesting action or signature must be submitted to Deputy County Clerk Vickie Eastin. However, a **copy** must be submitted to Sally Shoemaker for distribution of the packet and retention.
- As always, if you are unable to attend the meeting after being placed onto an agenda, please send a representative in your place or your item will be rescheduled.
- In order to determine placement on the agenda, please review the county website (www.sweet.wy.us/commissioner) on Thursday afternoon.
- If a request to be placed on an agenda is received **AFTER** the deadline, you will be considered for the next meeting date.
- No handout will be received during a meeting in session.

RESOLUTION NO. 14-12-CC-02
SWEETWATER COUNTY, WYOMING
A RESOLUTION APPROVING ADDITIONAL OFFICIAL HOLIDAYS
FOR COUNTY EMPLOYEES FOR THE YEAR 2014

WHEREAS, Chapter 7 Section 5 of the Sweetwater County Personnel Policy Manual provides for the observance of any holiday, as proclaimed by the Board or other state or federal official as set by the Sweetwater County Board of Commissioners; and

WHEREAS, per Wyoming Statute § 18-3-103 as amended, county officers shall keep their offices open during the usual business hours of each day excluding Saturdays, Sundays, legal holidays and other days as established by the County Commissioners through resolution; and

NOW THEREFORE BE IT RESOLVED by the Board of County Commissioners of Sweetwater County, Wyoming that the additional holidays shall be observed as days off for Sweetwater County employees and county offices shall close at noon on said holidays,

Christmas Eve ½ day (4 hours)	December 24, 2014
New Year's Eve ½ day (4 hours)	December 31, 2014

NOW THEREFORE BE IT FURTHER RESOLVED by the Board of County Commissioners of Sweetwater County, Wyoming that the additional holidays shall be observed as days off for Sweetwater County employees and county offices shall close the entire day on said holidays.

Day after Christmas (8 hours)	December 26, 2014
Day after New's Year Day (8 hours)	January 2, 2015

APPROVED, PASSED AND ADOPTED THIS 2nd day of December, 2014.

THE BOARD OF COUNTY COMMISSIONERS
OF SWEETWATER COUNTY, WYOMING

Wally J. Johnson, Chairman

Gary Bailiff, Member

John K. Kolb, Member

ATTEST:

Don Van Matre, Member

Steven Dale Davis, County Clerk

Reid O. West, Member

HIGHWAY SAFETY**FY- 2015 GRANT AGREEMENT (HS-3)**

Selective Traffic Enforcement Grant Program

APPLICANT AGENCY (Name & Address)

Department Name Sweetwater County SO
 Department Address 731 C Street #234
 City, State Zip Rock Springs, WY 82901

PROJECT NO. DUI 405D - 20.616
 OP HVE 405B - 20.616
 Motorcycle/Sturgis - 402 - 20.600
 Radars 402 - 20.600
 Video Camera 402 - 20.600

FUNDING PERIOD

From: 10/1/2014
 To: 9/30/2015

TITLE: Selective Traffic Enforcement Grant Program

REPORT PERIOD

From: 10/1/2014
 To: 10/15/2015

Start / or Revised Date:

TOTAL FUNDS APPROVED: \$18,300.00

Non-Major Equipment: Description of equipment

405D FUNDS: DUI \$13,800.00

405B FUNDS: OP HVE \$4,500.00

402 FUNDS: Motorcycle/Sturgis \$0.00

402 FUNDS: Radars \$0.00

402 FUNDS: Video Cameras \$ -

TOTAL FUNDS: \$18,300.00

Major Equipment: Description of equipment

Acceptance of Conditions: It is understood and agreed by the undersigned that a grant received as a result of this Agreement is subject to the regulations governing Grants under Section 402 and other applicable sections of the Highway Safety Act. NHTSA and FHWA Order as issued (e.g. NHTSA 460-6) and the rules and regulations set forth in the "Contract Management Manual". It is also understood and agreed that the undersigned will conduct the grant in a manner that meets the project description and performs the objectives within the budgeted amount allowed. The audit responsibility shall be addressed in this agreement. The sub-grantee must comply with applicable portions of OMB circular A-133 and any other federal documents that apply. The Highway Safety Program in conjunction with the WYDOT Internal Review staff will be available to assist the sub-grantee in determining if an A-133 audit is required.

PROJECT DIRECTOR:

TITLE: Sheriff **PHONE:** 307 822-5316

E-MAIL: haskell@sweet.wy.us

SIGNATURE: Richard Haskell

DATE: 11-20-14

AUTHORIZING OFFICIAL:

TITLE: Chairman **PHONE:** 307/872-3899

Sweetwater County Commission

E-MAIL: johnsonw@sweet.wy.us

SIGNATURE:

DATE:

APPROVAL: _____ **DATE:** _____

WASCOP/WYDOT - HIGHWAY SAFETY GRANTS PROGRAM

PO Box 990, DOUGLAS, WY 82633 PHONE (307) 351-8614 FAX (800) 954-0778

11-24-14
OKM

HIGHWAY SAFETY

FY-2015 GRANT APPLICATION (HS-1)

Selective Traffic Enforcement Grant Program/Department Allocation

Agency Requesting Funds: Sweetwater County Sheriffs Office

	Date	National/Local Activities	Safety Focus	For J&A Use Only	DUI Overtime	HVE Overtime	Supplemental Funding
N1	October 20-26, 2014	National Teen Driver Week	HVE				
N2	Oct 30 - November 2, 2014	Buzzed Driving	DUI				
N3	Nov 15 - 30, 2014	Click It-Don't Risk It	HVE			\$ 1,000.00	
N4	Dec 4 - 14, 2014	Buzzed Driving	DUI		\$ 2,000.00		
N5	Dec 14 - Jan 4, 2015	Over the Limit	DUI		\$ 2,000.00		
N6	Jan 30 - Feb 2, 2015	Superbowl	DUI		\$ 1,000.00		
N7	March 13-17, 2015	St. Patrick's Day	DUI		\$ 2,000.00		
N8	May 1-31, 2015	Motorcycle Awareness	HVE			\$ 1,000.00	
N9	May 11 - 25, 2015	May Mobilization	HVE			\$ 2,500.00	
N10	July 3-6, 2015	Fourth of July	DUI		\$ 2,000.00		
N11	Aug 19 - Sept 5, 2015	National Crackdown	DUI		\$ 2,500.00		
L1	July 24-August 2015	RDR/Fair	DUI		\$ 2,300.00		
L2							
L3							
L4							
L5							
L6							
L7							
L8							
L9							
L10							
L11							
L12	July 25 - August 15, 2015	Sturgis (Funded at same level as previous year)	OP				
TOTAL					\$ 13,800.00	\$ 4,500.00	\$ -

BUDGET: Please refer to the LISTING OF GRANT FUNDS AVAILABLE - BY AGENCY AND COUNTY

DUI event budget

Overtime Enforcement Budget: Total \$13,800.00

HVE event budget

Overtime Enforcement Budget: Total \$4,500.00

Non-Major Equipment: Radar Units Total _____

**AMENDMENT ONE TO THE CONTRACT BETWEEN
WYOMING DEPARTMENT OF HEALTH, PUBLIC HEALTH DIVISION
AND
SWEETWATER COUNTY**

1. **Parties.** This Amendment is made and entered into by and between the Wyoming Department of Health, Public Health Division [Agency], whose address is 6101 Yellowstone Road, Suite 420, Cheyenne, Wyoming 82002; and Sweetwater County, concerning the Tripartite Board, [Contractor], whose address is 80 West Flaming Gorge Way, Suite 19, Green River, WY 82935-4252. This Amendment pertains to the Community Services Block Grant (CSBG).

2. **Purpose of Amendment.** This Amendment shall constitute the first Amendment to the Contract between the Agency and the Contractor which was duly executed on September 24, 2014 and which became effective on October 1, 2014. The purpose of this Amendment is to: a) increase the total Contract dollar amount by Sixteen Thousand One Hundred Fifteen Dollars (\$16,115.00) to One Hundred Eighty-One Thousand Forty-Seven Dollars (\$181,047.00); and b) revise the Statement of Work, as set forth in Attachment A-1 to this Amendment.

The Original Contract, dated September 24, 2014, required the Contractor to provide services, as described in the Statement of Work, to low-income people for the total contract amount of One Hundred Sixty-Four Thousand Nine Hundred Thirty-Two Dollars (\$164,932.00) with an expiration date of September 30, 2015.

3. **Term of the Amendment.** The term of this Amendment shall commence upon the date of the last signature and shall remain in full force and effect through the term of the Contract, unless terminated at an earlier date pursuant to the provisions of the Contract, or pursuant to federal or state statute, rule or regulation.

4. **Amendments.** The Original Contract is hereby amended as follows:
 - A. The second sentence of Section 4 of the original Contract is hereby amended to read as follows:

“The total payment under this Contract shall not exceed One Hundred Eighty-One Thousand Forty-Seven Dollars (\$181,047.00).”

 - B. Attachment A is hereby superseded and replaced by Attachment A-1, the revised Statement of Work.

5. **Additional Responsibilities of Agency.** Responsibilities of the Agency have not changed.

6. **Additional Responsibilities of Contractor.** Responsibilities of the Contractor are hereby amended as follows:

A. Attachment A-1, the revised Statement of Work, describes the projects to be completed.

7. **Special Provisions.**

A. **Same Terms and Conditions.** With the exception of items explicitly delineated in this Amendment, all terms and conditions of the Contract between the Agency and the Contractor, including but not limited to sovereign immunity, shall remain unchanged and in full force and effect.

8. **General Provisions.**

A. **Entirety of Contract.** The Original Contract, consisting of twelve (12) pages, this Amendment One, consisting of three (3) pages, and Attachment A-1, Revised Statement of Work, consisting of two (2) pages, represents the entire and integrated Contract between the parties and supersedes all prior negotiations, representations, and agreements, whether written or oral. The parties recognize that this Contract, as amended, is subject to the FFY 2015 Wyoming CSBG State Management Plan and the Contractor's FFY CSBG Application, both of which can be located for review at the Agency.

THE REMAINDER OF THIS PAGE WAS INTENTIONALLY LEFT BLANK.

9. **Signatures.** IN WITNESS THEREOF, the parties to this Amendment through their duly authorized representatives have executed this Amendment on the days and dates set out below, and certify that they have read, understood, and agreed to the terms and conditions of this Amendment as set forth herein.

This Amendment is not binding on either party until approved by A&I Procurement and the Governor of the State of Wyoming or his designee, if required by Wyo. Stat. § 9-2-1016(b)(iv).

The Effective Date of this Amendment is the date of the signature last affixed to this page.

WYOMING DEPARTMENT OF HEALTH

Thomas O. Forslund, Director

Date

Wendy E. Braund, MD, MPH, MEd, FACPM, State Health Officer
and Senior Administrator, Public Health Division

Date

**CONTRACTOR:
SWEETWATER COUNTY**

County Commissioner

Date

ATTORNEY GENERAL'S OFFICE: APPROVAL AS TO FORM

Marion Yoder #123342

Marion Yoder, Senior Assistant Attorney General

Nov. 10, 2014

Date

*OK 11-26-14
MB*

**ATTACHMENT A-1
STATEMENT OF WORK
Community Services Block Grant**

General Description

This document is intended as a Statement of Work (SOW) to identify and describe projects to be performed through the Community Services Block Grant in Sweetwater County, Wyoming during the term of this Contract. The goal of the project is to provide activities and supportive services to low-income individuals and families that empower them to overcome the effects of poverty and to support their progress toward greater self-sufficiency.

Timeline and Deliverables

The following table shows specific projects, estimated number of clients to be served, amount of funding allocated to each project, and end dates. Sweetwater County through the Tripartite Board will provide eight (8) services and activities to low-income individuals and families until September 30, 2015 and will continuously pursue all options to effectively serve as many clients in need with the amount of funding granted to each project. The first payment for a quarter of the grant will be made upon execution of the Contract. Subsequent quarterly payments will be made after 20%, 45%, and 70% of the entire grant amount has been expended and used to deliver services to the clients as described below. Up to 20% of the total allocation can be shifted between the services and activities categories with prior approval by the Community Services Program Manager.

Sweetwater County				
Project	Program Name	Estimated Clients to be Served	Amount Funded	Grant End Date
	Description			
1	Southwest Wyoming Recovery Access Programs	50	\$26,359.00	9/30/2015
	Provide emergency medical, dental, optical, pharmaceutical, shelter, housing, utility, transportation, food, and household supplies assistance through the Basic Needs & Emergency Assistance Program.			
2	Sweetwater School District #1/ Head Start	76	\$57,115.00	9/30/2015
	Provide funding for a Head Start Family Advocate position and vehicle to assist income-eligible Head Start parents, guardians, or other caretakers by conducting family assessments; enabling opportunities for them to become involved in decision-making activities for their community; and providing self-development and enrichment activities enabling them to work toward their potential and gaining family stability.			
3	Tripartite Board	N/A	\$14,115.00	9/30/2015
	Provide oversight, monitoring, and indirect costs for the CSBG Program in Sweetwater County.			
4	Young at Heart – Early Learning Center	4	\$14,640.00	9/30/2015
	Provide childcare services to low-income working parents or parents furthering their education to work towards becoming economically self-sufficient.			

**ATTACHMENT A-1
STATEMENT OF WORK
Community Services Block Grant**

5	Young at Heart – Home Services	30	\$23,098.00	9/30/2015
	Provide home repairs, chore services for extreme circumstances and general household assistance for eligible low-income seniors and/or individuals with disabilities.			
6	Young at Heart – Meals	17	\$18,720.00	9/30/2015
	Provide “ready-to-eat” special-diet or regular home-delivered meals to low-income homebound seniors and disabled individuals.			
7	Young Women’s Christian Association (YWCA) – Early Care & Learning Center	35	\$12,000.00	9/30/2015
	Provide childcare services to low-income working parents or parents furthering their education to work towards becoming economically self-sufficient.			
8	Young Women’s Christian Association (YWCA) – Support & Safe House	9	\$15,000.00	9/30/2015
	Provide rent and utility assistance for three months, Allstate Financial Empowerment Program, and on-going services (basic computer skills, job search assistance, groups, parenting classes, counseling) to survivors of domestic violence and sexual assault to assist them in becoming self-sufficient in their violence-free life.			
TOTALS		221	\$181,047.00	9/30/2015

**AMENDMENT ONE TO THE
FY 2015 COMMUNITY SERVICES BLOCK GRANT SUBGRANTEE CONTRACT BETWEEN
SWEETWATER COUNTY AND
SWEETWATER COUNTY SCHOOL DISTRICT #1/HEAD START**

1. **Parties.** This Amendment is made and entered into by and between Sweetwater County [Agency], whose address is 80 West Flaming Gorge Way, Suite 19, Green River, Wyoming 82935; and Sweetwater County School District #1/Head Start, [Subgrantee], whose address is P.O. Box 1089, Rock Springs, Wyoming 82902-1089.
2. **Purpose of Amendment.** This Amendment shall constitute the first Amendment to the Subgrantee Contract between the Agency and the Contractor which was duly executed on September 30, 2014, and which became effective on October 1, 2014. The purpose of this Amendment is to: a) increase the total Subgrantee Contract dollar amount by Sixteen Thousand One Hundred Fifteen Dollars (\$16,115.00) to Fifty-Seven Thousand One Hundred Fifteen Dollars (\$57,115.00); and b) revise the Statement of Work, as set forth in Attachment A-1 to this Amendment.

The Original Contract, dated September 30, 2014, required the Subgrantee to provide services, as described in the Statement of Work, to low-income people for the total subgrantee contract amount of Forty-One Thousand Dollars (\$41,000.00) with an expiration date of September 30, 2015.

3. **Term of the Amendment.** The term of this Amendment shall commence upon the date of the last signature and shall remain in full force and effect through the term of the Contract, unless terminated at an earlier date pursuant to the provisions of the Contract, or pursuant to federal or state statute, rule or regulation.
4. **Amendments.** The Original Subgrantee Contract is hereby amended as follows:
 - A. The second sentence of Section 4 of the original Contract is hereby amended to read as follows:

"The total payment under this Contract shall not exceed Fifty-Seven Thousand One Hundred Fifteen Dollars (\$57,115.00)."
 - B. Attachment A is hereby superseded and replaced by Attachment A-1, the revised Statement of Work.
5. **Additional Responsibilities of Agency.** Responsibilities of the Agency have not changed.
6. **Additional Responsibilities of Contractor.** Responsibilities of the Subgrantee are hereby amended as follows:

- A. Attachment A-1, the revised Statement of Work, describes the projects to be completed.

7. **Special Provisions.**

- A. **Same Terms and Conditions.** With the exception of items explicitly delineated in this Amendment, all terms and conditions of the Subgrantee Contract between the Agency and the Subgrantee, including but not limited to sovereign immunity, shall remain unchanged and in full force and effect.

8. **General Provisions.**

- A. **Entirety of Contract.** The Original Subgrantee Contract, consisting of twelve (12) pages, this Amendment One, consisting of three (3) pages, and Attachment A-1, Revised Statement of Work, consisting of one (1) page, represents the entire and integrated Contract between the parties and supersedes all prior negotiations, representations, and agreements, whether written or oral. The parties recognize that this Subgrantee Contract, as amended, is subject to the FFY 2015 Wyoming CSBG State Management Plan and the Subgrantee's FFY CSBG Application, both of which can be located for review at the Agency.

THE REMAINDER OF THIS PAGE WAS INTENTIONALLY LEFT BLANK.

9. **Signatures.** The parties to this Subgrantee Contract, either personally or through their duly authorized representatives, have executed this Subgrantee Contract on the days and dates set out below, and certify that they have read, understood, and agreed to the terms and conditions of this Subgrantee Contract.

The effective date of this Subgrantee Contract is the date of the signature last affixed to this page.

AGENCY: SWEETWATER COUNTY

Wally J. Johnson, Chairman
Sweetwater County Commission

Date

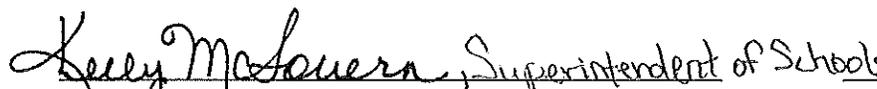
SWEETWATER COUNTY ATTORNEY'S OFFICE APPROVAL AS TO FORM



Marc Dedenbach,
Deputy County and Prosecuting Attorney

11-26-14
Date

SUBGRANTEE: SWEETWATER COUNTY SCHOOL DISTRICT #1/HEAD START

 Superintendent of Schools
Name and Title
 Head Start Director

11-20-14
Date

11/18/14

**ATTACHMENT A-1
STATEMENT OF WORK**

General Description

This document is intended as a Statement of Work (SOW) to identify and describe projects to be performed through the CSBG Program in Sweetwater County, Wyoming during the term of this Subgrantee Contract. The goal of the project is to provide activities and supportive services to low-income individuals and families empowering them to overcome the effects of poverty and to support their progress toward greater self-sufficiency.

Timeline and Deliverables

The following table shows the specific project, estimated number of clients to be served, amount of funding allocated to the project, and end date.

Program Name and Description	Estimated Clients to Be Served	Amount Funded	Grant End Date
Sweetwater County School District #1/Head Start	76	\$57,115.00	9/30/2015
Provide funding for a Head Start Family Advocate position and vehicle to assist income-eligible Head Start parents, guardians, or other caretakers by conducting family assessments; enabling opportunities for them to become involved in decision-making activities for their community; and providing self-development and enrichment activities enabling them to work toward their potential and gaining family stability.			

BOARD OF COUNTY COMMISSIONERS MEETING REQUEST FORM

Date Requested: December 2, 2014	Name & Title of Presenter: Robb Slaughter Sweetwater County Treasurer
Department or Organization: County Treasurer	Contact Phone & E-mail: 307-872-3720 slaughterr@sweet.wy.us
Exact Wording for Agenda: Cancellation of Warrants per Wyoming State Statute 18-4-106	Preference of Placement on Agenda & Amount of Time Requested for Presentation: 5 minutes
Will there be Handouts? (If yes, include with meeting request form) yes but n/a until day of meeting Robb will hand out to commissioners etc	Will handouts require SIGNATURES: no
Additional Information:	

- All requests to be added to the agenda will need to be submitted in writing on the "Meeting Request Form" by Wednesday at 12:00 p.m. prior to the scheduled meeting and returned in person or electronically to Clerk Sally Shoemaker at: shoemakers@sweet.wy.us
- All handouts are also due by Wednesday at 12:00 p.m. prior to the scheduled meeting date. Handouts may be submitted to Clerk Sally Shoemaker either in person or electronically. ****If your handout is not accompanied with the request to be added to the agenda, your request will be dismissed and you may reschedule for the next meeting provided the handout(s) are received.****
- Any documents requiring Board Action or signature are considered agenda items and need to be requested in the same manner.
- All original documents requesting action or signature must be submitted to Deputy County Clerk Vickie Eastin. However, a copy must be submitted to Sally Shoemaker for distribution of the packet and retention.
- As always, if you are unable to attend the meeting after being placed onto an agenda, please send a representative in your place or your item will be rescheduled.
- In order to determine placement on the agenda, please review the county website (www.sweet.wy.us/commissioner) on Thursday afternoon.
- If a request to be placed on an agenda is received AFTER the deadline, you will be considered for the next meeting date.
- No handout will be received during a meeting in session.

BOARD OF COUNTY COMMISSIONERS MEETING REQUEST FORM

Date Requested: 12-2-1	Name & Title of Presenter: Commissioners Robb Slaughter, County Treasurer
Department or Organization:	Contact Phone & E-mail:
Exact Wording for Agenda: Adendum to Specific Purpose Tax MOU for the CDC	Preference of Placement on Agenda & Amount of Time Requested for Presentation: 15 min
Will there be Handouts? (If yes, include with meeting request form) Yes	Will handouts require SIGNATURES: Yes
Additional Information: Robb will have MOU by Tuesday, November 25, 2014	

- All requests to be added to the agenda will need to be submitted in writing on the "Meeting Request Form" by Wednesday at 12:00 p.m. prior to the scheduled meeting and returned in person or electronically to Clerk Sally Shoemaker at: shoemakers@sweet.wy.us
- All handouts are also due by Wednesday at 12:00 p.m. prior to the scheduled meeting date. Handouts may be submitted to Clerk Sally Shoemaker either in person or electronically. *****If your handout is not accompanied with the request to be added to the agenda, your request will be dismissed and you may reschedule for the next meeting provided the handout(s) are received.*****
- Any documents requiring **Board Action** or **signature** are considered agenda items and need to be requested in the same manner.
- All **original** documents requesting action or signature must be submitted to Deputy County Clerk Vickie Eastin. However, a **copy** must be submitted to Sally Shoemaker for distribution of the packet and retention.
- As always, if you are unable to attend the meeting after being placed onto an agenda, please send a representative in your place or your item will be rescheduled.
- In order to determine placement on the agenda, please review the county website (www.sweet.wy.us/commissioner) on Thursday afternoon.
- If a request to be placed on an agenda is received **AFTER** the deadline, you will be considered for the next meeting date.
- No handout will be received during a meeting in session.

ADDENDUM TO MEMORANDUM OF UNDERSTANDING

THIS ADDENDUM to a Memorandum of Understanding is made this _____ day of _____, 2014, by and between Sweetwater County Child Developmental Center (CDC); Sweetwater County, by and through its Board of Commissioners (County), and Robb Slaughter, Sweetwater County Treasurer (Treasurer).

WHEREAS the parties executed a Memorandum of Understanding dated September 23, 2011 concerning collection and disbursement of sales tax revenue to CDC; and

WHEREAS in the memorandum it was acknowledged that there was a possibility that taxes collected may exceed the amount authorized by voters of Sweetwater County for the approved purposes of the tax; and

WHEREAS taxes collected exceeded the amount authorized by the voters; and

WHEREAS the Treasurer remains in possession of a portion of the excess taxes that were collected; and

WHEREAS the Memorandum of Understanding is unclear as to the authority of the Treasurer to invest excess taxes and if disbursement of excess taxes to CDC is done as provided in the Memorandum of Understanding the Treasurer will be holding excess taxes in perpetuity; and

WHEREAS the parties want to make clear that the Treasurer has the authority to invest excess taxes in any manner authorized by W.S. 9-4-831, and want to assure that excess taxes are ultimately disbursed and spent in the manner authorized by the voters of Sweetwater County.

NOW, THEREFORE, in consideration of the premises, the parties agree as follows:

1. Paragraph 4 of the Memorandum of Understanding is hereby cancelled and revoked and is replaced by the following Paragraph 4:
 4. The Parties hereto acknowledge the possibility that taxes collected may exceed the amount necessary for the approved purposes. In that event, the County Treasurer shall hold and distribute same as provided in W.S. 39-15-211(b)(iv) and W.S. 39-

16-211(b)(vii). It is the parties' understanding and agreement that a distribution of same 39.175% to the County and 60.825% to the City is in compliance with said statutes. The parties further acknowledge that the Treasurer has authority to invest undistributed tax proceeds in any manner permitted by W.S. 9-4-831. The parties agree that the Treasurer shall distribute the income realized from the investment of undistributed tax proceeds to CDC on an annual basis.

2. Paragraph 8 of the Memorandum of Understanding is hereby cancelled and revoked and is replaced by the following Paragraph 8:

8. Sweetwater County's obligations to the CDC are fully stated herein, in the Long Term Lease Agreement and in the Contact for Conveyance of Real Property. So as to avoid the necessity of the County Treasurer holding excess tax proceeds in perpetuity the County Treasurer, in addition to disbursing income annually, as above agreed, shall distribute \$50,000.00 of principal to the CDC each year until all excess tax proceeds and income earned thereon are fully distributed. CDC acknowledges and agrees that all disbursements received from the County Treasurer must be applied to operation and maintenance costs for the building and premises located at 4509 Foothill Boulevard, Rock Springs, Wyoming, and CDC agrees to keep records of expenditure of said disbursements showing compliance with these restrictions. After the distribution of all tax revenues described herein, Sweetwater County shall incur no future financial obligations to assist the CDC.

Remainder of this page intentionally left blank.

3. Except as specifically modified by this Addendum To Memorandum of Understanding, all other terms of the Memorandum of Understanding shall remain in full force and effect.

DATED this _____ day of _____, 2014.

CHILD DEVELOPMENTAL CENTER
OF SWEETWATER COUNTY, WYOMING

By: _____

THE BOARD OF COMMISSIONERS OF
SWEETWATER COUNTY, WYOMING

By: _____

ATTEST:

By: _____

Robb Slaughter,
Sweetwater County Treasurer

BOARD OF COUNTY COMMISSIONERS MEETING REQUEST FORM

Date Requested: BOCC- December 2, 2014	Name & Title of Presenter: John P. Radosevich Sweetwater County Engineer
Department or Organization: Engineering	Contact Phone & E-mail: 307-872-3921
Exact Wording for Agenda: Approval of BLM Right of Way Grant No. WYW183919 (Yellowstone Road)	Preference of Placement on Agenda & Amount of Time Requested for Presentation: 5 minutes
Will there be Handouts? (If yes, include with meeting request form) Yes	Will handouts require SIGNATURES: Board Approval and authorize Chairman to sign all necessary documents.
Additional Information:	

- All requests to be added to the agenda will need to be submitted in writing on the "Meeting Request Form" by Wednesday at 12:00 p.m. prior to the scheduled meeting and returned in person or electronically to Clerk Sally Shoemaker at: shoemakers@sweet.wy.us
- All handouts are also due by Wednesday at 12:00 p.m. prior to the scheduled meeting date. Handouts may be submitted to Clerk Sally Shoemaker either in person or electronically. *****If your handout is not accompanied with the request to be added to the agenda, your request will be dismissed and you may reschedule for the next meeting provided the handout(s) are received.*****
- Any documents requiring **Board Action or signature** are considered agenda items and need to be requested in the same manner.
- All **original** documents requesting action or signature must be submitted to Deputy County Clerk Vickie Eastin. However, a **copy** must be submitted to Sally Shoemaker for distribution of the packet and retention.
- As always, if you are unable to attend the meeting after being placed onto an agenda, please send a representative in your place or your item will be rescheduled.
- In order to determine placement on the agenda, please review the county website (www.sweet.wy.us/commissioner) on Thursday afternoon.
- If a request to be placed on an agenda is received **AFTER** the deadline, you will be considered for the next meeting date.
- No handout will be received during a meeting in session.



United States Department of the Interior

BUREAU OF LAND MANAGEMENT

Rock Springs Field Office
280 Highway 191 North
Rock Springs, Wyoming 82901-3447

In Reply Refer To:
2800 (WYD04)
WYW183919

NOV 10 2014

John Radosevich
Sweetwater County
80 W. Flaming Gorge Way
Green River, WY 82935

Re: Yellowstone Road Light Poles

Dear Mr. Radosevich:

Enclosed are two copies of the revised right-of-way (R/W) grant offer on Bureau of Land Management (BLM) Form 2800-14, for your proposed light poles and electric conduit, BLM serial number WYW183919. The R/W grant was revised to reflect the survey plat BLM received on November 5, 2014. Please review the offer and if it meets with your approval, sign and date in the space provided, and return both copies to the address shown above. Upon receipt of the signed grant offer, the BLM will be able to issue the R/W grant absent any other unresolved issues.

You are allowed 30 days from receipt of this offer in which to submit the executed right-of-way grant. If this requirement is not met, the application may be denied.

This R/W grant, and the authority to use the lands described in the document, becomes effective on the date it is signed by an authorized officer of BLM. A copy of the R/W grant will be returned to you when signed by the authorized officer.

If you have any questions, please contact me at 307-352-0334.

Sincerely,

Patricia Hamilton
Lead Realty Specialist

Attachment

UNITED STATES
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
RIGHT-OF-WAY GRANT/TEMPORARY USE PERMIT

SERIAL NUMBER WYW183919

1. A right-of-way is hereby granted pursuant to Title V of the Federal Land Policy and Management Act of October 21, 1976 (90 Stat. 2776; 43 U.S.C. 1761).
2. Nature of Interest:
 - a. By this instrument, the holder:

Sweetwater County
80 West Flaming Gorge Way
Green River, WY 82935

receives a right to construct, operate, maintain, and terminate a(n) one (1) 35 foot high light pole, four (4) control boxes and a two (2) inch electric conduit, on public lands described as follows:

T. 19 N., R. 105 W., 6th P.M., Sweetwater County, Wyoming
section 4: NW¼SE¼
 - b. The right-of-way or permit area granted herein is 20 feet wide, 1,440 feet long and contains 0.66 acres, more or less.
 - c. This instrument shall terminate on December 31, 2043, 30 years from its effective date unless, prior thereto, it is relinquished, abandoned, terminated, or modified pursuant to the terms and conditions of this instrument or of any applicable Federal law or regulation.
 - d. This instrument may be renewed. If renewed, the right-of-way or permit shall be subject to the regulations existing at the time of the renewal and any other terms and conditions that the authorized officer deems necessary to protect the public interest.

- e. Notwithstanding the expiration of this instrument or any renewal thereof, early relinquishment, abandonment, or termination, the provisions of this instrument, to the extent applicable, shall continue in effect and shall be binding on the holder, its successors, or assigns, until they have fully satisfied the obligations and/or liabilities accruing herein before or on account of the expiration, or prior termination, of the grant.

3. Rental

For and in consideration of the rights granted, the holder agrees to pay the Bureau of Land Management fair market value rental as determined by the authorized officer unless specifically exempted from such payment by regulation. Provided, however, that the rental may be adjusted by the authorized officer, whenever necessary, to reflect changes in the fair market rental value as determined by the application of sound business management principles, and so far as practicable and feasible, in accordance with comparable commercial practices.

4. Terms and Conditions:

- a. This grant or permit is issued subject to the holder's compliance with all applicable regulations contained in Title 43 Code of Federal Regulations part 2800 and 2880.
- b. Upon grant termination by the authorized officer, all improvements shall be removed from the public lands within 90 days, or otherwise disposed of as provided in paragraph (4)(d) or as directed by the authorized officer.
- c. Each grant issued for a term of 20 years or more shall, at a minimum, be reviewed by the authorized officer at the end of the 20th year and at regular intervals thereafter not to exceed 10 years. Provided, however, that a right-of-way or permit granted herein may be reviewed at any time deemed necessary by the authorized officer.
- d. The stipulations, plans, maps, or designs set forth in Exhibit(s) A and B, dated November 5, 2014; Exhibit C, dated September 22, 2014, attached hereto, are incorporated into and made a part of this grant instrument as fully and effectively as if they were set forth herein in their entirety.

- e. Failure of the holder to comply with applicable law or any provision of this right-of-way grant or permit shall constitute grounds for suspension or termination thereof.
- f. The holder shall perform all operations in a good and workmanlike manner so as to ensure protection of the environment and the health and safety of the public.
- g. The holder shall contact the authorized officer at least FIVE days prior to the anticipated start of construction and/or any surface disturbing activities. The authorized officer may require and schedule a preconstruction conference with the holder prior to the holder's commencing construction and/or surface disturbing activities on the right-of-way. The holder and/or his representative shall attend this conference. The holder's contractor, or agents involved with construction and/or any surface disturbing activities associated with the right-of-way, shall also attend this conference to review the stipulations of the grant including the plan(s) of development.
- h. In the event that the public land underlying the right-of-way (ROW) encompassed in this grant, or a portion thereof, is conveyed out of Federal ownership and administration of the ROW or the land underlying the ROW is not being reserved to the United States in the patent/deed and/or the ROW is not within a ROW corridor being reserved to the United States in the patent/deed, the United States waives any right it has to administer the right-of-way, or portion thereof, within the conveyed land under Federal laws, statutes, and regulations, including the regulations at 43 CFR Part 2800, including any rights to have the holder apply to BLM for amendments, modifications, or assignments and for BLM to approve or recognize such amendments, modifications, or assignments. At the time of conveyance, the patentee/grantee, and their successors and assigns, shall succeed to the interests of the United States in all matters relating to the right-of-way, or portion thereof, within the conveyed land and shall be subject to applicable State and local government laws, statutes, and ordinances. After conveyance, any disputes concerning compliance with the use and the terms and conditions of the ROW shall be considered a civil matter between the patentee/grantee and the ROW Holder.
- i. The holder shall construct, operate, and maintain the facilities, improvements, and structures within this right-of-way in strict conformity with the plan(s) of development which was (were) approved and made part of the grant on _____ . Any relocation, additional construction, or use that is not in accord with the approved plan(s) of development, shall not be initiated without the prior written approval of the authorized officer. A copy of the complete right-

of-way grant, including all stipulations and approved plan(s) of development, shall be made available on the right-of-way area during construction, operation, and termination to the authorized officer. Noncompliance with the above will be grounds for an immediate temporary suspension of activities if it constitutes a threat to public health and safety or the environment.

- j. The holder shall designate a representative(s) who shall have the authority to act upon and to implement instructions from the authorized officer. The holder's representative shall be available for communication with the authorized officer within a reasonable time when construction or other surface disturbing activities are underway.
- k. Any cultural and/or paleontological resource (historic or prehistoric site or object) discovered by the holder, or any person working on his behalf, on public or Federal land shall be immediately reported to the authorized officer. Holder shall suspend all operations within 100 feet of the immediate area of such discovery. If the discovery is suspected to include human remains then all operations within 300 feet of the discovery shall be suspended. Work within the vicinity of the discovery may not proceed until written authorization to proceed is issued by the authorized officer. An evaluation of the discovery will be made by the authorized officer to determine appropriate actions to prevent the loss of significant cultural or scientific values. The holder will be responsible for the cost of evaluation and any decision as to proper mitigation measures will be made by the authorized officer after consulting with the holder.
- l. Use of pesticides shall comply with the applicable Federal and state laws. Pesticides shall be used only in accordance with their registered uses and within limitations imposed by the Secretary of the Interior. Prior to the use of pesticides, the holder shall obtain from the authorized officer written approval of a plan showing the type and quantity of material to be used, pest(s) to be controlled, method of application, location of storage and disposal of containers, and any other information deemed necessary by the authorized officer. Emergency use of pesticides shall be approved in writing by the authorized officer prior to such use.
- m. The holder shall be responsible for weed control on disturbed areas within the limits of the right-of-way. The holder is responsible for consultation with the authorized officer and/or local authorities for acceptable weed control methods (within limits imposed in the grant stipulations).
- n. Seed shall be planted using a drill equipped with a depth regulator to ensure proper depth of planting where drilling is possible. The seed mixture shall be evenly and uniformly planted over the disturbed area (smaller/heavier seeds have a tendency to drop to the bottom of the drill and are planted first). The holder shall take appropriate

measures to ensure this does not occur. Where drilling is not possible, seed shall be broadcast and the area shall be raked or chained to cover the seed. When broadcasting the seed, the pounds per acre noted below are to be doubled. The seeding will be repeated until a satisfactory stand is established as determined by the authorized officer. Evaluation of growth will not be made before completion of the first growing season after seeding. The authorized officer is to be notified a minimum of five days prior to seeding of the project.

Seed Mixture

Species of seed	Pounds/acre PLS
<u>Grasses--USE ALL</u>	
Thickspike wheatgrass	6
Indian ricegrass	2
Sandberg bluegrass or bluebunch wheatgrass	6
Bottlebrush squirreltail	2
<u>Shrubs--USE TWO</u>	
Basin or Wyoming big sagebrush	1
shadscale	1
winterfat	2
Gardners saltbush	2
<u>Forbs--USE TWO</u>	
scarlet globemallow	1/2
lupine	1/2
blue flax	1/4
Rocky Mountain penstemon	1/4

Pure Live Seed (PLS) formula: % of purity of seed mixture times % germination of seed mixture = portion of seed mixture that is PLS.

- o. The holder shall protect all survey monuments found within the right-of-way. Survey monuments include, but are not limited to, General Land Office and Bureau of Land Management Cadastral Survey Corners, reference corners, witness points, U.S. Coastal and Geodetic benchmarks and triangulation stations, military control monuments, and recognizable civil (both public and private) survey monuments. In the event of obliteration or disturbance of any of the above, the holder shall

immediately report the incident, in writing, to the authorized office and the respective installing authority if known. Where General Land Office or Bureau of Land Management right-of-way monuments or references are obliterated during operations, the holder shall secure the services of a registered land surveyor or a Bureau cadastral surveyor to restore the disturbed monuments and reference using surveying procedures found in the Manual of Surveying Instructions for the Survey of the Public Lands in the United States, latest edition. The holder shall record such survey in the appropriate county and send a copy to the authorized officer. If the Bureau cadastral surveyors or other Federal surveyors are used to restore the disturbed survey monument, the holder shall be responsible for the survey cost.

- p. No construction or routine maintenance activities shall be performed during periods when the soil is too wet to adequately support construction equipment or when watershed damage is likely to occur. If such equipment creates ruts in excess of four inches deep, the soil shall be deemed too wet to adequately support construction equipment. Frozen soil or soil mixed with snow will not be used in construction.
- q. The holder shall meet Federal, State, and local emission standards for air quality.
- r. Construction-related traffic shall be restricted to routes approved by the authorized officer. New access roads or cross-country vehicle travel will not be permitted unless prior written approval is given by the authorized officer. Authorized roads used by the holder shall be rehabilitated or maintained when construction activities are complete as approved by the authorized officer.
- s. Except rights-of-way expressly authorizing a road after construction of the facility is completed, the holder shall not use the right-of-way as a road for purposes other than routine maintenance as determined necessary by the authorized officer in consultation with the holder.
- t. Prior to termination of the right-of-way, the holder shall contact the authorized officer to arrange a pretermination conference. This conference will be held to review the termination provisions of the grant.

IN WITNESS WHEREOF, The undersigned agrees to the terms and conditions of this right-of-way grant or permit.

(Signature of Holder)

(Signature of Authorized Officer)

(Title)

Assistant Field Manager
Minerals and Lands

(Title)

(Date)

(Effective Date of Grant)

YELLOWSTONE ROAD(CR4-58) PLAN OF DEVELOPMENT AMENDMENT

11/3/2014

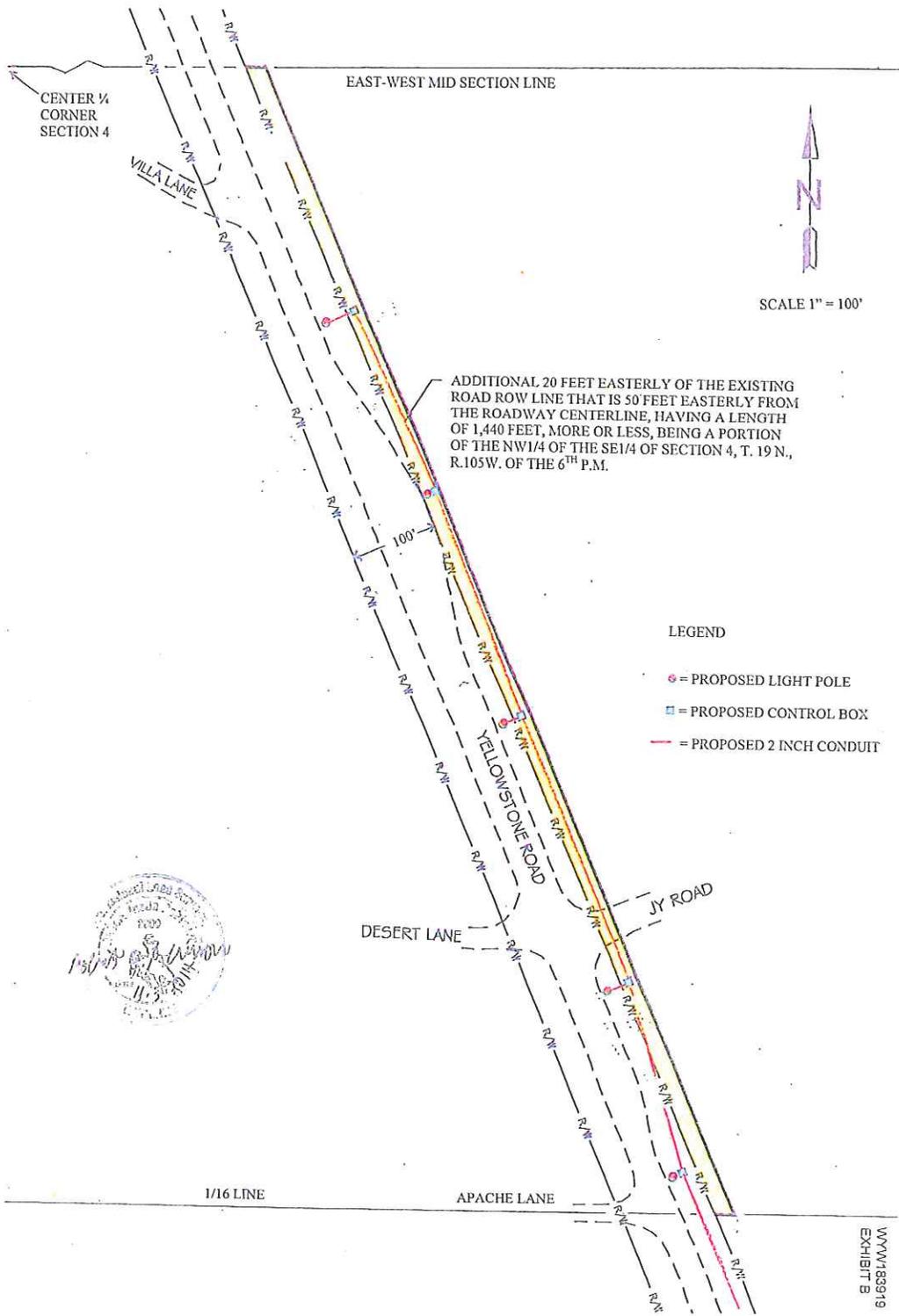
This amendment to the original Plan of Development is to construct 5 light poles, related control boxes, and electric conduit, as shown on the attached map. To clarify further, there would be 4 light poles, and 1 control box in the existing 100 feet wide roadway, and 1 light pole, and 4 control boxes, in the proposed 20 feet wide right-of-way grant.

Robert J. Robinson

County Surveyor



- ☆ Professional
- ☆ Resourceful
- ☆ Innovative
- ☆ Dedicated
- ☆ Efficient



CENTER 1/4
CORNER
SECTION 4

EAST-WEST MID SECTION LINE

SCALE 1" = 100'

ADDITIONAL 20 FEET EASTERLY OF THE EXISTING ROAD ROW LINE THAT IS 50 FEET EASTERLY FROM THE ROADWAY CENTERLINE, HAVING A LENGTH OF 1,440 FEET, MORE OR LESS, BEING A PORTION OF THE NW1/4 OF THE SE1/4 OF SECTION 4, T. 19 N., R. 105 W. OF THE 6TH P.M.

LEGEND

- = PROPOSED LIGHT POLE
- = PROPOSED CONTROL BOX
- = PROPOSED 2 INCH CONDUIT



WMM/133919
EXHIBIT B

Plan of Development Yellowstone Road Right-of-Way Addition

1. Introduction and Background

1.1 Introduction. Yellowstone Road is the main thoroughfare from Rock Springs to the county residences to the north. The road begins in the Rock Springs City Limits and continues northwesterly. As the road passes through Section 4, T 19 N, R 105 W, 6th P.M., it traverses through public and private land. Toward the intersection of JY Road, the road widens to accommodate a turning lane. As the road passes JY Road, the road widens further to accommodate a mailbox turnout. The right-of-way also has a gas pipeline and a water main that parallel the road in and out of the right-of-way.

1.2 Background. Yellowstone Road has undergone many improvements over the past several years. As part of these improvement, the county has installed state of the art LED street lighting through the first 2 miles of the project, from the intersection of US 191 through the fairgrounds at the intersection of Gannett Drive and Yellowstone Road. The new lights provide added safety to the most congested section of Yellowstone Road. In an effort to provide additional safety to the county residents of North Rock Springs, the County recently awarded a project to extend the lights from Gannett Drive North to the Mailbox Turnout at JY Road.

The project involves trenching in new 2" conduit, boring under the road approaches, installing new 3' Ø x 10' deep drilled shaft concrete piers to support the new 35' poles, and other miscellaneous work. The project commenced in August 2014. During the trenching operations, the electrical contractor determined that the most safe and reasonable place to dig the trench at turning lane for JY Road was the edge of the right-of-way, 50' from the centerline of Yellowstone Road. The contractor then followed the edge of pavement for the road, and exited the right-of-way limits.

~~While inspecting the placement of the conduit, the engineer representing the county discovered that the trench left the right-of-way. Upon further inspection it was also discovered that the construction of the mailbox turnout also encroached outside the right-of-way. This application and Plan are intended to add additional right-of-way to include the previously installed improvements.~~

2. Purpose and Need.

2.1 Proponent of the Project. Sweetwater County is the owner of the road and the roadway lights. The intention of the new grant is to add to the existing right-of-way so the installed improvements are within the right-of-way. The proposed addition to the right-of-way is an additional 20' Northeastly of the existing Northeastly right-of-way, from the East-West Section line of Section 4 for

2.2 Need of the Project. As explained above, some of the improvements have been installed for years, and the additional right-of-way was never acquired. The proposed additional right-of-way will cover the existing and proposed improvements. The proposed lighting upgrades will provide additional safety and security to the existing roadway. There are many arguments that justify the need for the roadway lights. The portion of roadway that is being extended is largely a mixed land use with mostly commercial and industrial businesses directly along the road and residential immediately behind. The road is also a recreational corridor with many all-terrain vehicles crossing and paralleling the road through the entirety of the project. The lights will allow drivers to better see the ATV's, pedestrians, commercial vehicle movements, and a host of other reasons.

2.3 Existing Improvements. At the Northern-most end of the proposed lighting extension is a mailbox turnout. The mailbox turnout services the residences north of Rock Springs. The existing turnout is unlit and encroaches outside the existing right-of-way.

2.4 Purpose of New Improvements. As previously stated, the purpose of the proposed lighting is to provide the traveling public with additional safety. Night driving can be dangerous due to the commercial and industrial traffic, and the recreational traffic in the area. The lights will provide drivers with the additional sight to anticipate and plan a reaction to driving conditions that may exist and change at a moment's notice.

3. Project Description.

The proposed lights are on 35' steel poles with 8' extension arms. The lights are LED lights that run very efficiently and are specifically designed to illuminate the road. The lights are serviced from a proposed service point in the north one-third of the project. The wire is carried through 2 inch buried conduit. Each pole has its own pull box allowing the proper splicing for each electrical connection. The pull boxes are installed flush with the ground.

3.1 Proposed Lighting and Underground Conduit Location Description. As previously stated, the Yellowstone Road corridor is also a utility route servicing areas north of Rock Springs. A 16-inch water main is currently installed within the right-of-way. Through a portion of the route, a gas line is also installed in the right-of-way. Where the road is a typical width of two lanes, there is enough room to install underground electrical service maintaining the proper clearances away from the gas and water lines. However, as turning lanes and the mailbox turnout are added to the width of the road, unsafe clearances would exist if the power trench were to strictly follow the edge of the road at a constant distance. In order to place the buried electrical service in the most safe location, the contractor relocated the trench outside the right-of-way and on BLM lands.

3.2 Proposed Lighting Components. The proposed lights are on 35' steel poles with 8' extension arms. The roadway lights are high efficiency LED lights. The lights are serviced by an electrical service point and the wire is carried through 2 inch buried conduit. Each pole has its

own pull box allowing the proper splicing for each electrical connection. The pull boxes are installed flush with the ground.

3.3 Land Requirements and Construction Disturbance. The minimum land required to allow proper placement of the conduit and lighting appurtenances is 20' adjacent to the existing right-of-way. Since the request is for additional right-of-way adjacent to existing right-of-way, the access to the additional right-of-way is minimal. The electrical trenching is merely one foot in width and three feet deep. All access to the lighting and appurtenances will be from the existing roadway and right-of-way.

3.3.1 Right-of-Way Acquisition. The minimum land required to allow proper placement of the conduit and lighting appurtenances is 20' adjacent to the existing right-of-way. A scaled map is included in this Plan of Development to detail the additional right-of-way requested.

3.3.2 Land Disturbance. The electrical trenching is merely one foot in width and three feet deep. The light pole foundations are 3' \varnothing x 10' deep. The pull boxes are approximately 1' x 2.5' x 2.5'. With all components of the system, the land disturbance will be a minimum required to properly install the individual components. Since the disturbance involves excavation and backfilling, there will be some dirt scattered across existing vegetation. Areas disturbed will be reseeded as necessary.

3.3.3 Access to BLM Property. The additional right-of-way will be adjacent to existing right-of-way and so access needs to the additional area requested will be minimal. A scaled map is included in this Plan of Development to detail the additional right-of-way requested.

3.3.4 Lighting System Construction. The lighting system will be installed in accordance with the project plans and specifications. The minimum standards of National Electrical Code, Wyoming Public Works Standards, as well as County Road Design Standards will be followed.

3.3.5 Site Staging and Trash. The County has provided a staging area for the project South at the fairgrounds. Trash removal is completed daily at the end of each shift. The project is inspected daily for upkeep of grounds. Any issues identified are immediately address as required by the contract.

4. Operation, Maintenance, and Abandonment.

4.1 Operation of Lighting System. The lighting system is set up so that it is virtually maintenance free, and operates from a central control cabinet on a positional based variable timer. The lights will automatically turn on prior to sunset, and turn off shortly after sunrise. Operation of the system will largely be conducted from the shoulder of Yellowstone Road. The system is designed to operate for twenty years before the lights need to be replaced.

4.2 Maintenance of the Lighting System. Once the system is placed into operation, it will only require maintenance resulting from a failure of some type. We anticipate that such a failure would most likely be from an accident. Again, most of the maintenance would be conducted from the shoulder of the road and leaving the roadway would not be necessary. The maintenance of the system may include the occasional marking of the trench when other utility maintenance is conducted on the adjacent utilities.

4.3 Maintenance of Right-of-Way. The maintenance of the right-of-way will continue to be conducted as the existing right-of-way currently is conducted. Mowers, plows, and other equipment may enter the right-of-way from time to time to ensure that the roadway and appurtenances are clear and operational. The County does not anticipate any additional efforts expended to maintain the additional right-of-way.

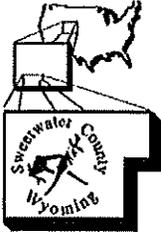
4.4 Emergency Response. The county is the primary responder for any emergencies in the county. Emergencies will be routed through the proper chain of command and responses to emergencies will be seamless and quick. This includes fire responses to any situations in the right-of-way.

4.5 Abandonment. Any abandonment of the proposed lighting system will require the partial or total removal of the lighting system and its appurtenances. The county will satisfy any requirements for removal if this is ever abandoned.

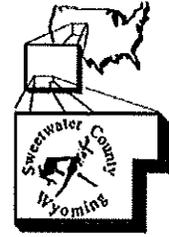
BOARD OF COUNTY COMMISSIONERS MEETING REQUEST FORM

Date Requested: 12/2/2014	Name & Title of Presenter: Garry McLean
Department or Organization: Human Resources	Contact Phone & E-mail: 307-872-3913
Exact Wording for Agenda: Health Insurance Plan amendment	Preference of Placement on Agenda & Amount of Time Requested for Presentation: 5 min.
Will there be Handouts? (If yes, include with meeting request form) yes	Will handouts require SIGNATURES: yes
Additional Information:	

- All requests to be added to the agenda will need to be submitted in writing on the "Meeting Request Form" by Wednesday at 12:00 p.m. prior to the scheduled meeting and returned in person or electronically to Clerk Sally Shoemaker at: shoemakers@sweet.wy.us
- All handouts are also due by Wednesday at 12:00 p.m. prior to the scheduled meeting date. Handouts may be submitted to Clerk Sally Shoemaker either in person or electronically. *****If your handout is not accompanied with the request to be added to the agenda, your request will be dismissed and you may reschedule for the next meeting provided the handout(s) are received.*****
- Any documents requiring **Board Action or signature** are considered agenda items and need to be requested in the same manner.
- All **original** documents requesting action or signature must be submitted to Deputy County Clerk Vickie Eastin. However, a **copy** must be submitted to Sally Shoemaker for distribution of the packet and retention.
- As always, if you are unable to attend the meeting after being placed onto an agenda, please send a representative in your place or your item will be rescheduled.
- In order to determine placement on the agenda, please review the county website (www.sweet.wy.us/commissioner) on Thursday afternoon.
- If a request to be placed on an agenda is received **AFTER** the deadline, you will be considered for the next meeting date.
- No handout will be received during a meeting in session.



Sweetwater County Department of Human Resources



80 W. Flaming Gorge Way, Suite 17
Green River WY 82935

E-MAIL: swchr@sweet.wy.us

Phone: 307-922-5429 (RS)
307-872-3910 (GR)
Fax: 307-872-3996

MEMORANDUM

To: Board of County Commissioners
From: Garry McLean 
Date: November 24, 2014
RE: UMR Health Insurance Summary Plan Description Amendment

As you may be aware, the provisions of the Affordable Care Act (ACA) have been implemented in stages. Each year since 2010, employers have had to make changes to their health insurance Summary Plan Description (SPD) to implement specific provisions in order to be in compliance with the ACA.

As such, please find attached Amendment 01 to the County's SPD, which summarizes the changes to the County's plan, effective 7/1/2014. I have also attached a copy of the amended pages with the details of the changes to the plan.

The most notable change due to the ACA, is the requirement for health insurance plans to remove any reference to a pre-existing condition.

**Amendment 01
Effective July 1, 2014
SWEETWATER COUNTY**

The Health Benefit Summary Plan Description is amended as follows:

1. The INTRODUCTION is amended to revise the following:

You may also contact the U.S. Department of Health and Human Services at www.cciio.cms.gov.

This document summarizes the benefits and limitations of the Plan and will serve as the SPD and Plan document. Therefore it will be referred to as both the Summary Plan Description ("SPD") and Plan document.

2. The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 001, is amended to revise the following:

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, 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.

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.

Maternity:		
Routine Prenatal Services:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery And Postnatal Care:		
• Paid By Plan After Deductible	80%	60%

3. The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 001, is amended to delete the following:

Individual Annual Maximum <i>Note: The Plan Guarantees A Minimum Of \$2,000,000 Of This Maximum Will Be For Essential Benefits.</i>	\$2,500,000
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4. The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 002, is amended to revise the following:

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, 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.

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.

Maternity:		
Routine Prenatal Services:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery And Postnatal Care:		
• Paid By Plan After Deductible	80%	60%

5. The MEDICAL SCHEDULE OF BENEFITS, Plan(s) 002, is amended to delete the following:

Individual Annual Maximum <i>Note: The Plan Guarantees A Minimum Of \$2,000,000 Of This Maximum Will Be For Essential Benefits.</i>	\$2,500,000
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6. The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 003, is amended to revise the following:

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, 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.

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.

Maternity:		
Routine Prenatal Services:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery And Postnatal Care:		
• Paid By Plan After Deductible	80%	60%

7. The MEDICAL SCHEDULE OF BENEFITS, Plan(s) 003, is amended to delete the following:

Individual Annual Maximum <i>Note: The Plan Guarantees A Minimum Of \$2,000,000 Of This Maximum Will Be For Essential Benefits.</i>	\$2,500,000
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8. The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 004, is amended to revise the following:

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, 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.

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.

Maternity:		
Routine Prenatal Services:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery And Postnatal Care:		
• Paid By Plan After Deductible	80%	60%

9. The MEDICAL SCHEDULE OF BENEFITS, Plan(s) 004, is amended to delete the following:

Individual Annual Maximum <i>Note: The Plan Guarantees A Minimum Of \$2,000,000 Of This Maximum Will Be For Essential Benefits.</i>	\$2,500,000
---	-------------

10. The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 005, is amended to revise the following:

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, 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.

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.

Maternity:		
Routine Prenatal Services:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery And Postnatal Care:		
• Paid By Plan After Deductible	80%	60%

11. The MEDICAL SCHEDULE OF BENEFITS, Plan(s) 005, is amended to delete the following:

Individual Annual Maximum <i>Note: The Plan Guarantees A Minimum Of \$2,000,000 Of This Maximum Will Be For Essential Benefits.</i>	\$2,500,000
--	-------------

12. The TRANSPLANT SCHEDULE OF BENEFITS, Benefit Plan(s) 001, 002, 003, 004, 005, is amended to revise the following:

Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	
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13. The PRESCRIPTION SCHEDULE OF BENEFITS, Benefit Plan(s) 001, 002, 003, 004, 005, is amended to revise the following:

Specialty Drugs <ul style="list-style-type: none"> • Covered Person's Co-pay Amount Generic Drugs (Tier 1) Brand-Name Drugs (Tier 2)	For Up To A 31-Day Supply: 20% With A Maximum Of \$250 20% With A Maximum Of \$250
<i>Note: Specialty Drugs Must Be Purchased At A Specialty Pharmacy Vendor.</i>	

14. The PRESCRIPTION SCHEDULE OF BENEFITS, Benefit Plan(s) 006, is amended to revise the following:

Specialty Drugs <ul style="list-style-type: none"> • Covered Person's Co-pay Amount Generic Drugs (Tier 1) Preferred Brand-Name Drugs (Tier 2) Nonpreferred Brand-Name Drugs (Tier 3)	For Up To A 31-Day Supply: 33% 33% 33%
<i>Note: Specialty Drugs Must Be Purchased At A Specialty Pharmacy Vendor.</i>	

15. The INDIVIDUAL ANNUAL MAXIMUM BENEFIT portion of the OUT-OF-POCKET EXPENSES AND MAXIMUMS, Applies to Benefit Plan(s) 001, 002, 003, 004, 005, provision is deleted.

16. The ELIGIBILITY AND ENROLLMENT provision is amended to revise the following:

ELIGIBILITY REQUIREMENTS

An eligible Dependent includes:

- Your legal spouse, as defined by the state in which You reside, provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. 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. A covered Employee's spouse who has group coverage available through his/her own employer must participate in that employer's coverage before he/she can be covered as a Dependent under this Plan. This does not apply to those couples who both work for Sweetwater County.

ANNUAL OPEN ENROLLMENT PERIOD

Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

17. The ELIGIBILITY AND ENROLLMENT provision is amended to add the following:

ELIGIBILITY REQUIREMENTS

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

18. The PRE-EXISTING CONDITION PROVISION is deleted.

19. The HIPAA PORTABILITY RIGHTS provision is deleted.

20. The COBRA CONTINUATION OF COVERAGE provision is amended to delete the following:

SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)

If You or Your Dependent will be obtaining group health coverage through a new employer, keep in mind that HIPAA requires employers to reduce Pre-Existing Condition exclusion periods if there is less than a 63-day break in health coverage (Creditable Coverage).

21. The COBRA CONTINUATION OF COVERAGE provision is amended to revise the following:

EARLY TERMINATION OF COBRA CONTINUATION

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.

SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)

At the time of a COBRA Qualifying Event, a Qualified Beneficiary has two primary options. The first is to waive his or her right to COBRA and make an election for coverage, whether group health coverage or insurance coverage through the individual market or the exchanges, in accordance with his or her HIPAA special enrollment rights. Please refer to the Special Enrollment section for further details. The second option is to elect COBRA continuation coverage. 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 as 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.

22. The HEALTH COVERAGE TAX CREDIT PROGRAM (HCTC) portion of the COBRA CONTINUATION OF COVERAGE provision is deleted.

23. The UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 provision is amended to revise the following:

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 leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. 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 cannot be subject to Waiting Periods.

24. The PROVIDER NETWORK, Applies to Benefit Plan(s) 001, 002, 003, 004, 005, provision is amended to revise the following:

- **The program for Transplant Services at Designated Transplant Facilities is:**

25. The COVERED MEDICAL BENEFITS provision is amended to revise the following:

Autism Spectrum Disorders (ASD) Treatment, when Medical Necessity is met.

(ASD includes Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, Rett Syndrome and Pervasive Developmental Disorders).

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.

Treatment is prescribed and provided by a licensed healthcare professional practicing within the scope of their license.

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).

Does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Investigational/Experimental or Unproven, custodial, nutrition-diet supplements, educational or services that should be provided through the school district).

Breast Pumps and related supplies. Coverage is subject to Medical Necessity as defined by this Plan. Contact the Plan regarding limits on frequency, duration, or type of equipment that is covered.

Durable Medical Equipment (Applies to Benefit Plan(s) 001, 002, 003, 004, 005) subject to all of the following:

- The equipment is subject to review under the Care Management provision of this SPD, if applicable.

Emergency Services Provided in a Foreign Country, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital or Physician services in a provider's office, as shown in the Schedule of Benefits.

Extended Care Facility Services (Applies to Benefit Plan(s) 001, 002, 003, 004, 005) for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. The Covered Person must obtain prior authorization for services in advance. (Refer to the Care Management section of this SPD). The following benefits are covered:

Maternity Benefits for Covered Persons include:

- Hospital or Birthing Center room and board.
- Vaginal delivery or Cesarean section.
- Non-routine prenatal care.
- Postnatal care.
- Medically Necessary diagnostic testing.
- Abdominal operation for intrauterine pregnancy or miscarriage.
- Midwives.

Preventive / Routine Care (Applies to Benefit Plan(s) 001, 002, 003, 004, 005) as listed under the Schedule of Benefits.

Please visit the following links for additional information:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits/>

or

<http://www.hrsa.gov/womensguidelines/>

Qualifying Clinical Trials as defined below, including routine patient care costs as defined below 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; and
- Cardiovascular disease (cardiac/stroke) that is not life threatening, for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below; and

- Surgical musculoskeletal disorders of the spine, hip and knees, that are not life threatening, for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below; and
- Other diseases or disorders that are not life threatening for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below.

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 (i.e., 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.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip, and knees and other diseases or disorders that are not life-threatening, a Qualifying Clinical Trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder 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 the Veteran's Administration (VA);*
 - *A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or*
 - *The Department of Veterans Affairs, the Department of Defense, 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 *National Institutes of Health*; 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.

26. The HOME HEALTH CARE BENEFITS, Applies to Benefit Plan(s) 001, 002, 003, 004, 005, provision is amended to revise the following:

Home Health Care services are provided for patients when Medically Necessary as determined by the Utilization Review Organization.

Covered Persons must obtain prior authorization before receiving services. Please refer to the Care Management section of this SPD for more details. Covered services may include:

- Nutrition counseling provided by or under the supervision of a registered dietician.

27. The TRANSPLANT BENEFITS, Applies to Benefit(s) 001, 002, 003, 004, 005, provision is amended to revise the following:

Refer to the Care Management section of this SPD for prior authorization requirements

COVERED EXPENSES

- Pancreas, if the transplant meets the criteria determined by Care Management.

28. The PRESCRIPTION DRUG BENEFITS provision is amended to revise the following:

Prescription Drug Benefit Highlights

Prescription Drug Benefits will not be coordinated with those of any other health coverage plan.

29. The PRESCRIPTION DRUG BENEFITS provision is amended to add the following:

COVERED BENEFITS - What the Prescription Drug Benefits Section Will Cover

- **Vaccines.** Some vaccines may be covered, and may have limitations depending on whether the vaccine is administered in a pharmacy or a clinic.

EXCLUSIONS - What the Prescription Benefits Section of this Plan Will Not Cover

- Tobacco cessation products;

30. The **PRESCRIPTION DRUG BENEFITS** provision is amended to delete the following:

DEFINITIONS

Prescription Drug

- Insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and

31. The **MENTAL HEALTH BENEFITS** Applies to Benefit Plan(s) 001, 002, 003, 004, 005, provision is amended to delete the following:

COVERED BENEFITS

- The Covered Person must have the ability to accept treatment.

32. The **MENTAL HEALTH BENEFITS** Applies to Benefit Plan(s) 001, 002, 003, 004, 005, provision is amended to revise the following:

COVERED BENEFITS

- This Plan also covers services provided at a residential treatment facility that is licensed by the state in which it operates and that provides treatment for Mental Health Disorders. There is an MD/psychiatrist on staff. Coverage does not include services provided at a group home. Treatment in a residential treatment facility is not for the purpose of providing custodial care. If outside the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

33. The **SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY BENEFITS** Applies to Benefit Plan(s) 001, 002, 003, 004, 005, provision is amended to delete the following:

COVERED BENEFITS

- The Covered Person must have the ability to accept treatment.

34. The **UTILIZATION MANAGEMENT** provision is deleted and replaced with the **CARE MANAGEMENT** provision.

CARE MANAGEMENT

Utilization Management

Utilization Management is the process of evaluating whether services, supplies or treatment is Medically Necessary and appropriate to help ensure cost-effective 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.

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. Covered Persons should call 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 fact-gathering and independent medical review, if necessary.

Special Notes: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who have received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or after Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

This Plan complies with the Newborns and Mothers Health Protection Act. Prior Authorization is not required to certify Medical Necessity 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: **UMR CARE MANAGEMENT**

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 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 services, tests or procedures 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.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the Medical Necessity, effectiveness and appropriateness of health care services and treatment plans. 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.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, over \$1,500 or any Durable Medical Equipment rentals over \$500/month.
- Prosthetics over \$1,000.
- Qualifying Clinical Trials.
- Inpatient stays in a Hospital or Birthing Center that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.

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).

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 of \$250 will be applied to applicable claims if a Covered Person receives services but does not obtain the required Prior Authorization for:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, over \$1,500 or any Durable Medical Equipment rentals over \$500/month.
- Prosthetics over \$1,000.
- Qualifying Clinical Trials.
- Inpatient stays in a Hospital or Birthing Center that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.

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.

Medical Director Oversight. A UMR 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.

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. Case management opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points including the following criteria: length of stay, level of care, readmission and utilization, as well as employer or self-referrals. Information is easily passed from Utilization Management to case management through our fully-integrated care management software system.

All Prior Authorization requests are used to identify the member's needs. 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 is conducted by Plan Administrator request as long as the request is received within 30 days of the original determination. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures.

Maternity Management

Maternity Management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of a long term hospital stay for both the mother and/or baby. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment is performed at that time to determine the member's risk level and educational needs. The program uses incentives in order to increase participation. The standard incentive is a gift card. Covered Persons who enroll via the web receive a special edition pregnancy information guide. UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they're pregnant. Members self-enroll in the pre-pregnancy coaching program by calling our toll-free number. They are then contacted by a nurse case manager who has extensive clinical background in obstetrics/gynecology. The nurse completes a pre-pregnancy assessment to determine risk level, if any, and provides them with education and materials based on their needs. The nurse also helps members understand their Plan's benefit information.

Case Management

Case Management services are designed to identify catastrophic and complex illnesses, transplants and trauma cases. UMR Care Management's nurse case managers identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly inpatient stays. Opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission and utilization, as well as employer or self-referrals. UMR Care Management works directly with the patient, the patient's family members, the treating Physician and the facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious illness helps avoid major complications in the future. The Covered Person may request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

NurseLine

NurseLine service is a health information line that is available 24 hours per day, seven days a week that assists Covered Persons with medical-related questions and concerns. NurseLine gives Covered Persons access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their Dependents.

35. The COORDINATION OF BENEFITS provision is amended to add the following:

The Plan will coordinate benefits with the following types of medical or dental plans:

- This Plan does not, however, coordinate benefits with individual health or dental plans.

ORDER OF BENEFIT DETERMINATION RULES

- 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.

36. The GENERAL EXCLUSIONS provision is amended to revise the following:

Foreign Coverage for Medical Care Expenses, Which Includes Preventive Care or Elective Treatment, except for services that are incurred in the event of an Emergency. Emergency room Hospital and Physician services, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital, or Physician services in a provider's office, as shown in the Schedule of Benefits.

37. The GENERAL EXCLUSIONS provision is amended to delete the following:

Pre-Existing Conditions exclusions, as specified in the Pre-Existing Condition Provision section of this SPD.

38. The CLAIMS AND APPEAL PROCEDURES provision is amended to revise the following:

TYPE OF CLAIMS AND DEFINITIONS

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.

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.

NOTIFICATION OF BENEFIT DETERMINATION

Note: For Prescription benefits, a Covered Person will receive an EOB when he or she files a claim directly with OptumRx. See Procedures for Submitting Claims for more information.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

First Level of Appeal:

- 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 You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Second Level of Appeal:

- 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 You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

39. The CLAIMS AND APPEAL PROCEDURES provision is amended to delete the following:

TIMELINES FOR INITIAL BENEFIT DETERMINATION

- Emergency and/or Urgent Care Claim: 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.

40. The OTHER FEDERAL PROVISIONS is amended to revise the following:

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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.

41. The HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION is amended to revise the following:

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

- 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;

42. The HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION is amended to add the following:

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

- 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;

43. The GLOSSARY OF TERMS provision is amended to revise the following:

Essential Health Benefit means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; Emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and Pediatric Services, including oral and vision care, if applicable.

44. The GLOSSARY OF TERMS provision is amended to add the following:

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Pediatric Services means services provided to individuals under the age of 19.

45. The GLOSSARY OF TERMS provision is amended to delete the following:

Certificate of Creditable Coverage

Creditable Coverage

Pre-Existing Condition

Significant Break In Coverage

BY THIS AGREEMENT,
The SWEETWATER COUNTY Health Benefit Summary Plan Description
is amended July 1, 2014.

Authorized Signature _____

Print Name _____

Title _____

Date _____

IMPORTANT NOTICE:

The employer agrees to all provisions of this amendment as the basis for Plan administration. Except as specifically stated above, nothing in this amendment will alter or amend the summary plan description.

Any applicable stop loss policies typically rely on formally approved amendments or updated summary plan descriptions when determining whether reimbursement is appropriate. Failure to notify the stop loss carrier of plan changes may result in a stop loss gap or lapse in coverage. Notice to the stop loss carrier of all plan changes is required.

Please sign and return this amendment to your UMR strategic account executive as soon as possible. Note, however, that since the corresponding system changes have been implemented, these changes are considered final, regardless of whether or not a signature is received. If you have any questions, please contact your UMR strategic account executive.

Contingent upon your signed approval of the initial plan document, this amendment will be posted to the UMR member portal upon UMR's receipt of your signature, or within 14 days of your receipt of the amendment if a signature is not received by UMR. Please note that UMR will not print amendments or booklets until a signature is received.

Remember to keep a copy for your records.

SWEETWATER COUNTY
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 information on a Covered Person's rights and obligations under the SWEETWATER COUNTY Health Benefit Plan (the "Plan"). As a valued Employee of SWEETWATER COUNTY, we are pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions.

SWEETWATER COUNTY is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of 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 OptumRx for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, as 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, 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.

The Plan Administrator believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

80 W FLAMING GORGE WAY
STE 17
GREEN RIVER WY 82935
307-872-3910

Amendment 1

Update:
www.cciio.cms.gov

You may also contact the U.S. Department of Health and Human Services at <http://www.healthcare.gov>.

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in the Glossary of Terms, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Glossary will help to better understand the provisions of this Plan.

Individuals covered under this Plan will be receiving an identification card to present to the provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

This document summarizes the benefits and limitations of the Plan and is known as a Summary Plan Description ("SPD"). ADD: Therefore it will be referred to as both the Summary Plan Description ("SPD") and Plan document.

This document becomes effective on July 1, 2013.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 001

Benefit Plans 001;002;003;004;005
Amendments 2 - 11

All health benefits shown on this Schedule of Benefits are subject to the following: ~~Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any.~~ Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this 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.

Update: Care Management

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 Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Notes: 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, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum Note: The Plan Guarantees A Minimum Of \$2,000,000 Of This Maximum Will Be For Essential Benefits.	\$2,500,000	
Annual Deductible Per Calendar Year:		
• Per Person	\$500	\$500
• Per Family	\$1,000	\$1,000
Plan Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Out-Of-Pocket Maximum Excluding The Prescription Benefit Out-of-Pocket:		
• Per Person	\$2,000	\$2,000
• Per Family	\$3,000	\$3,000
Ambulance Transportation:		
• Paid By Plan After In-Network Deductible	80%	80%
Breast Pumps:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Chiropractic Services:		
• Co-pay Per Visit	\$20	\$20
• Maximum Visits Per Calendar Year	20 Visits	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Contraceptive Methods And Counseling Approved By The FDA:		
For Men:		
• Paid By Plan After Deductible	80%	60%
For Women:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

Delete

Benefit Plans 001;002;003;004;005
Amendments 2 - 11

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgery / Surgeon Charges: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
Inpatient Occupational / Speech Rehab Therapy: <ul style="list-style-type: none"> • Maximum Days Per Calendar Year • Paid By Plan After Deductible 	80%	45 Days 60%
Maternity: Update: Routine Prenatal Services: ☐ Paid By Plan After Deductible		
Prenatal: <ul style="list-style-type: none"> • Paid By Plan After Deductible Update: Non-Routine Prenatal Services, Delivery And Postnatal Care:	100% (Deductible Waived)	60%
Delivery And Postnatal: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
Mental Health, Substance Abuse And Chemical Dependency Benefits:		
Inpatient Services / Physician Charges: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
Residential Treatment: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
Outpatient Or Partial Hospitalization Services And Physician Charges: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
Office Visit: <ul style="list-style-type: none"> • Co-pay Per Visit • Maximum Benefit Per Visit • Paid By Plan After Deductible 	\$20 \$200 100% (Deductible Waived)	Not Applicable Not Applicable 60%
<ul style="list-style-type: none"> • After Maximum Is Satisfied • Paid By Plan After Deductible 	80%	60%
Physician Office Services: <ul style="list-style-type: none"> • Co-pay Per Visit • Maximum Benefit Per Visit • Paid By Plan After Deductible 	\$20 \$200 100% (Deductible Waived)	Not Applicable Not Applicable 60%
<ul style="list-style-type: none"> • After Maximum Is Satisfied • Paid By Plan After Deductible 	80%	60%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: <ul style="list-style-type: none"> • From Age 7 Through 18 • Dollar Maximum Per Calendar Year • From Age 19 Through 40 • Dollar Maximum Per Calendar Year • From Age 41 Through 49 • Dollar Maximum Per Calendar Year • 50 And Up • Dollar Maximum Per Calendar Year 		\$250 \$400 \$600 \$800

TRANSPLANT SCHEDULE OF BENEFITS	
Benefit Plan(s) 001, 002, 003, 004, 005	
Effective: 07-11-2013	
Transplant Services At A Designated Transplant Facility:	
Transplant Services:	
<ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%
Travel And Housing:	
<ul style="list-style-type: none"> • Maximum Benefit Per Transplant • Paid By Plan 	\$10,000 100% (Deductible Waived)
Travel And Housing At Designated Transplant Facility For Up To One Year From Date Of Transplant.	

see below for update

Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.

PRESCRIPTION SCHEDULE OF BENEFITS OPTUMRX							
Benefit Plan(s) 001, 002, 003, 004, 005							
Annual Out-of-Pocket Maximum Per Calendar Year: <ul style="list-style-type: none"> • Per Person • Per Family <p>Applies to: Retail And Mail Order Only</p> <p>Once The Annual Out-Of-Pocket Maximum Is Met, Then The Covered Person Pays Zero For Covered Prescription Medication, Except For The Difference Cost Between Brand And It's Generic Equivalent.</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">\$2,000</td> <td style="width: 50%;"></td> </tr> <tr> <td>\$4,000</td> <td></td> </tr> </table>	\$2,000		\$4,000			
\$2,000							
\$4,000							
By Participating Retail Pharmacy <ul style="list-style-type: none"> • Covered Person's Co-pay Amount <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Generic Drugs (Tier 1)</td> <td style="width: 50%;">\$7 + 20%</td> </tr> <tr> <td>Preferred Brand-Name Drugs (Tier 2)</td> <td>\$20 + 20%</td> </tr> <tr> <td>Nonpreferred Brand-Name Drugs (Tier 3)</td> <td>\$40 + 20%</td> </tr> </table>	Generic Drugs (Tier 1)	\$7 + 20%	Preferred Brand-Name Drugs (Tier 2)	\$20 + 20%	Nonpreferred Brand-Name Drugs (Tier 3)	\$40 + 20%	<p>For Up To A 31-Day Supply:</p>
Generic Drugs (Tier 1)	\$7 + 20%						
Preferred Brand-Name Drugs (Tier 2)	\$20 + 20%						
Nonpreferred Brand-Name Drugs (Tier 3)	\$40 + 20%						
Retail 90 Rx By Participating Retail Pharmacy <ul style="list-style-type: none"> • Covered Person's Co-pay Amount <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Generic Drugs (Tier 1)</td> <td style="width: 50%;">\$21 + 20%</td> </tr> <tr> <td>Preferred Brand-Name Drugs (Tier 2)</td> <td>\$60 + 20%</td> </tr> <tr> <td>Nonpreferred Brand-Name Drugs (Tier 3)</td> <td>\$120 + 20%</td> </tr> </table>	Generic Drugs (Tier 1)	\$21 + 20%	Preferred Brand-Name Drugs (Tier 2)	\$60 + 20%	Nonpreferred Brand-Name Drugs (Tier 3)	\$120 + 20%	<p>For Up To A 3 Month Supply: (At Least 84 Days)</p>
Generic Drugs (Tier 1)	\$21 + 20%						
Preferred Brand-Name Drugs (Tier 2)	\$60 + 20%						
Nonpreferred Brand-Name Drugs (Tier 3)	\$120 + 20%						
By Participating Mail Order Pharmacy <ul style="list-style-type: none"> • Covered Person's Co-pay Amount Per Prescription Drug <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Generic Drugs (Tier 1)</td> <td style="width: 50%;">\$14 + 20%</td> </tr> <tr> <td>Preferred Brand-Name Drugs (Tier 2)</td> <td>\$40 + 20%</td> </tr> <tr> <td>Nonpreferred Brand-Name Drugs (Tier 3)</td> <td>\$80 + 20%</td> </tr> </table>	Generic Drugs (Tier 1)	\$14 + 20%	Preferred Brand-Name Drugs (Tier 2)	\$40 + 20%	Nonpreferred Brand-Name Drugs (Tier 3)	\$80 + 20%	<p>For Up To A 90-Day Supply:</p>
Generic Drugs (Tier 1)	\$14 + 20%						
Preferred Brand-Name Drugs (Tier 2)	\$40 + 20%						
Nonpreferred Brand-Name Drugs (Tier 3)	\$80 + 20%						
By Specialty Pharmacy Vendor <ul style="list-style-type: none"> • Covered Person's Co-pay Amount <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Generic Drugs (Tier 1)</td> <td style="width: 50%;">20% With A Maximum Of \$250</td> </tr> <tr> <td>Brand-Name Drugs (Tier 2)</td> <td>20% With A Maximum Of \$250</td> </tr> </table>	Generic Drugs (Tier 1)	20% With A Maximum Of \$250	Brand-Name Drugs (Tier 2)	20% With A Maximum Of \$250	<p style="text-align: center;">31</p> <p>For Up To A 30-Day Supply</p> <div style="border: 1px solid red; padding: 2px; font-size: small;"> ADD: Note: Specialty Drugs Must Be Purchased At A Specialty Pharmacy Vendor. </div>		
Generic Drugs (Tier 1)	20% With A Maximum Of \$250						
Brand-Name Drugs (Tier 2)	20% With A Maximum Of \$250						
By Non-Participating Pharmacy	<p>Use Of A Non-Participating Pharmacy, Requires Payment For The Prescription Upfront. The Covered Person Can Then Submit A Claim Reimbursement Form With A Receipt To OptumRx For Reimbursement. Reimbursement For Covered Prescription Drugs Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.</p>						

Note: Deductible and/or co-pay may not apply to preventive prescription products and contraceptives.

Note: The difference in cost between a Generic drug and a Brand-name drug when the medical professional has not specified a Brand-name drug or has not indicated that the Brand is necessary.

PRESCRIPTION SCHEDULE OF BENEFITS	
Benefit Plan(s) 006	
Annual Deductible Covered Persons Must Pay Before Initial Coverage Begins:	
• Per Person	\$0
Annual Out-of-Pocket Maximum Per Calendar Year:	
• Per Person	\$4,550
Once The Annual Out-Of-Pocket Maximum Is Met, Then The Covered Person Pays 5% For Covered Prescription Medication.	
By Participating Retail Pharmacy	
• Covered Person's Co-pay Amount	For Up To A 31-Day Supply:
Generic Drugs (Tier 1)	\$4
Preferred Brand-Name Drugs (Tier 2)	\$38
Nonpreferred Brand-Name Drugs (Tier 3)	50%
By Participating Mail Order Pharmacy	
• Covered Person's Co-pay Amount Per Prescription Drug	For Up To A 93-Day Supply:
Generic Drugs (Tier 1)	\$12
Preferred Brand-Name Drugs (Tier 2)	\$114
Nonpreferred Brand-Name Drugs (Tier 3)	50%
By Specialty Pharmacy Vendor	
• Covered Person's Co-pay Amount	For Up To A 31-Day Supply
Generic Drugs (Tier 1)	33%
Preferred Brand-Name Drugs (Tier 2)	33%
Nonpreferred Brand-Name Drugs (Tier 3)	33%
By Non-Participating Pharmacy	No Benefit

ADD: Note: Specialty Drugs Must Be Purchased At A Specialty Pharmacy Vendor.

*The "total drug costs" means the total amount Covered Persons have paid for covered drugs plus what the Plan has paid for the Calendar Year. This does not include the Plan premium Covered Persons pay.

**The "out-of-pocket" cost means the amount Covered Persons have paid for covered drugs for the Calendar Year. This does not include the amount the Plan has paid or the Plan premium Covered Persons pay.

Amendment 15

- Individual and family Deductibles.
- Expenses Incurred as a result of failure to comply with prior authorization requirements for Hospital confinement.
- Any amounts over the 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 all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the total out-of-pocket maximum.

~~INDIVIDUAL ANNUAL MAXIMUM BENEFIT~~

delete

~~All benefit options under the Plan are integrated and Essential and Non-Essential Health Benefits Incurred under one benefit option will be applied against all benefit options. Covered Persons will not receive a new Annual Maximum Benefit if they change benefit options midyear.~~

~~All Essential or Non-Essential Health Benefits will count toward the Covered Person's individual medical Annual Maximum Benefit that is shown on the Schedule of Benefits. Please note that \$2,500,000 of the Annual Maximum is guaranteed for Essential Benefits.~~

~~The Schedule of Benefits contains separate Maximum Benefit limitations for specified conditions. All separate Maximum Benefits are part of, and not in addition to, the Maximum Benefit.~~

~~For Covered Persons who were terminated from the Plan and are reinstated after a lapse in coverage of more than 30 days (for example, a Covered Person ends employment and later is re-hired and re-enrolls in this Plan), the Annual Maximum Benefit will start over.~~

Amendment 16

An eligible Dependent includes:

Update: Your legal spouse, as defined by the state in which You reside

- ~~Your legal spouse who is a husband or wife of the opposite sex in accordance with the federal Defense of Marriage Act~~ provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a common-law marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. 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. A covered Employee's spouse who has group coverage available through his/her own employer must participate in that employer's coverage before he/she can be covered as a Dependent under this Plan. This does not apply to those couples who both work for Sweetwater County.
- A Dependent Child that resides in the United States until the Child reaches his or her 26th birthday. The term "Child" includes the following Dependents:
 - A natural biological Child;
 - A step Child;
 - 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 who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO).
- A Dependent does not include the following:
 - A foster Child;
 - A Child of a Domestic partner or under Your Domestic Partner's Legal Guardianship;
 - A grandchild;
 - Domestic Partners;
 - Any other relative or individual unless explicitly covered by this Plan;
 - A Dependent Child if the Child is covered as a Dependent of another Employee at this company.

Eligibility Criteria: To be an eligible Totally Disabled Dependent Child, the following conditions must all be met:

- A Totally Disabled Dependent Child age 26 and over must be incapable of self-sustaining employment due to mental or physical disability.
- A Totally Disabled Dependent Child age 26 and over must be dependent upon the Employee for primary support and maintenance.
- A Totally Disabled Dependent Child age 26 and over must be unmarried.

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 a notice obligation to notify the Plan should the Dependent's eligibility status change throughout the Plan year. Please notify Your Human Resources Department regarding status changes.

Amendment 17

Add:

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 31 days of acquiring the Dependent; or
- July 1 following application during the annual open enrollment period. The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 30 days of Your hire date, or more than 31 days following the date You acquire the Dependent; or
- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 31 days following the event; or
- The later of the date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent, if additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PROVISION

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Eligible Employees and their Dependents who enroll during the annual open enrollment period will be considered Late Enrollees. Covered Employees will be able to make a change in coverage for themselves and their eligible Dependents.

Amendment 16 cont.

Coverage Waiting Periods and ~~Pre-Existing Condition Limits~~ are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent become covered under this Plan as a result of electing coverage during the annual open enrollment period, the following shall apply:

- The annual open enrollment period shall typically be in the month of May. The employer will give eligible Employees written notice 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 shall be July 1 following the annual open enrollment period.
- Retirees are not eligible for open enrollment period and will not be eligible to reenroll once the Retiree drops coverage or if coverage is terminated.

PRE-EXISTING CONDITION PROVISION

Amendment 18. Entire
Section deleted

Note: Pre-Existing Condition exclusions will not apply to any Covered Person under the age of 19.

A Pre-Existing Condition means an Illness or Injury for which medical advice, diagnosis, care or treatment was recommended or received within the three consecutive month period ending on the Covered Person's Enrollment Date. Medical advice, diagnosis, care or treatment (including taking prescription drugs) is taken into account only if it is recommended or received from a licensed Physician.

This Plan has an exclusion for Pre-Existing Conditions. Benefits will not be paid for Covered Expenses for a Pre-Existing Condition until the earliest of the following:

- 12 consecutive months from the Covered Person's Enrollment Date, if You apply for coverage when You are initially eligible for coverage or under Special Enrollment; or
- 12 consecutive months from the Covered Person's Enrollment Date, if the Covered Person is considered a Late Enrollee.

These times can be reduced by proof of Creditable Coverage as described below.

EXCEPTIONS

The Pre-Existing Condition exclusion does not apply to:

- Any person who, on the Enrollment Date, had 12 consecutive months of Creditable Coverage.
- Pregnancy, including complications.
- Prescriptions dispensed at a retail pharmacy, mail order pharmacy, or through a specialty pharmacy vendor.
- Genetic information, in the absence of a diagnosis of an Illness related to such information. For example, if You have a family history of diabetes but You Yourself have had no problem with diabetes, the Plan will not consider diabetes to be a Pre-Existing Condition just because You have a family history of this disease.
- Treatment recommendations made prior to the six consecutive month period before the Enrollment Date when the Covered Person did not act upon the recommendation.
- Any Employees or Dependents added as a result of an acquisition of an entire company or entire division moving into this Plan will be effective upon notification by the Employer to the Plan Administrator. The Pre-Existing Condition exclusion period under this Plan will apply. However, the Plan Administrator, in its discretion, may waive the Pre-Existing Condition exclusion period with respect to all similarly situated Employees who were covered under the other employer's group health plan at the time of such acquisition and/or honor any shorter Pre-Existing Condition exclusion period contained in such other employer's group health plan.

REDUCTION OF PRE-EXISTING CONDITION EXCLUSION TIME PERIOD (Creditable Coverage)

If on the Enrollment Date, a Covered Person has less than 12 consecutive months of Creditable Coverage, the Plan will reduce the length of the Pre-Existing Condition exclusion period for each day of Creditable Coverage the Covered Person had in determining whether the Pre-Existing Condition exclusion applies. See the HIPAA Portability Rights section of this SPD for more information on obtaining a Certificate of Creditable Coverage.

Creditable Coverage means that the Covered Person had coverage under a group health plan, health insurance policy, Medicare or any one of several other health plans as described in the Glossary of Terms section of this SPD, and coverage was not interrupted by a Significant Break in Coverage.

If a Covered Person has a Significant Break in Coverage, any days of Creditable Coverage that occur before the Significant Break in Coverage will not be counted by the Plan to reduce the Pre-Existing Condition exclusion time period. Waiting Periods will not count towards a Significant Break in Coverage. In addition, the days between the date an individual loses health care coverage and the first day of the second COBRA election period under the Trade Act of 2002 will not count towards a Significant Break in Coverage.

THE RIGHT TO REQUEST A REVIEW OF A DETERMINATION OF PRE-EXISTING CONDITION EXCLUSION PERIOD

If a Covered Person feels that a determination of the Pre-Existing Condition Exclusion (PCE) period is incorrect, the Covered Person may submit a written request for review.

Send Your request to:

UMR
ENROLLMENT SERVICES
PO BOX 30543
SALT LAKE CITY UT 84130-0543

The written request must be made within 60 days from the date of the notice. However, if the request is based on additional evidence that shows that You or Your Dependent had more Creditable Coverage than recognized originally, the Covered Person may take longer.

The written request should state the reasons that the Covered Person believes the original determination is incorrect and include any additional facts or evidence that shows that You or Your Dependent had more Creditable Coverage.

The request will usually be decided within 60 days after it is submitted. If additional time is needed to complete the review, the Covered Person will be notified. The Covered Person will be notified in writing of the decision on the request if the Covered Person submits additional evidence to consider or if the original Determination of PCE period is modified. The Covered Person's original determination of PCE period will remain in effect until or unless the Covered Person receives written notification verifying a change from the original decision.

Similar to an initial determination, any new determination will set forth:

- The specific reason(s) for the decision; and
- The specific Plan provision(s) and other documents or information on which the decision is based.

HIPAA PORTABILITY RIGHTS

Amendment 19.
entire section is
deleted.

CERTIFICATES OF CREDITABLE COVERAGE

New Employees and covered Dependents are encouraged to get a Certificate of Creditable Coverage from the individual's prior employer or insurance company. However, not all forms of coverage are required to provide certificates. If You or Your Dependents are having difficulty obtaining this, contact Your Human Resources or Personnel office for assistance.

Covered Persons will receive a Certificate of Creditable Coverage from this Plan when the person loses coverage under this Plan, when the person loses COBRA coverage, or upon a written request to this Plan if the individual is covered under this Plan or terminated from this Plan within the previous twenty four month period. The Certificate of Creditable Coverage is evidence of Your coverage under this Plan. Covered Persons may need evidence of coverage to reduce a Pre-Existing Condition exclusion period under another plan, to help get special enrollment in another plan, or to get certain types of individual health coverage.

Please submit written requests for a Certificate of Creditable Coverage from this Plan to:

UMR
ENROLLMENT SERVICES
PO BOX 30543
SALT LAKE CITY UT 84130-0543

Keep these Certificates in a safe place in case You or Your Dependents obtain coverage under another health plan that has a Pre-Existing Condition Exclusion Provision or become eligible for a Special Enrollment period under another plan. Proof of prior Creditable Coverage may reduce or eliminate the Pre-Existing Condition exclusion period, may be required to enroll in another plan under Special Enrollment, or may assist individuals in obtaining an individual insurance policy in the future.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any Pre-Existing Condition(s) for the beneficiary.
- 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.

Amendment 21 continued:
this section updated see
attached

SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)

Electing COBRA continuation coverage now may protect some of Your (or Your Dependent's) rights if You or Your Dependent need to obtain an **individual health insurance policy** soon. The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance carriers who offer coverage in the individual market must accept any eligible individuals who apply for coverage without imposing Pre-Existing Condition exclusions, under certain conditions. Some of those conditions pertain to COBRA continuation coverage. To take advantage of this HIPAA right, COBRA continuation coverage under this Plan must be elected and maintained (by paying the cost of coverage) for the duration of the COBRA continuation period. In the event that an individual health insurance policy is needed, You or Your Dependent must apply for coverage with an individual health insurance carrier after COBRA continuation coverage is exhausted and before a 63-day break in coverage.

Amendment 20 Delete the following paragraph:

~~If You or Your Dependent will be obtaining group health coverage through a new employer, keep in mind that HIPAA requires employers to reduce Pre-Existing Condition exclusion periods if there is less than a 63-day break in health coverage (Creditable Coverage).~~

HEALTH COVERAGE TAX CREDIT PROGRAM (HCTC)

Amendment 22 This section deleted

~~The Trade Act of 2002 created a new health coverage tax credit for certain individuals who become eligible for trade adjustment assistance. Trade adjustment assistance is generally available to only a limited group of individuals who have lost their jobs or suffered a reduction in hours as a result of import competition or shifts of production to other countries. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including COBRA continuation coverage. If You have questions about these new tax provisions, You may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is available at www.doleta.gov/tradeact/~~

~~Special COBRA rights apply to certain Employees who are eligible for the health coverage tax credit. These Employees are entitled to a second opportunity to elect COBRA coverage during a special second election period (if the Employee did not elect COBRA coverage already). The special second COBRA election period lasts 60 days or less, beginning on the first day of the month in which the Employee becomes an eligible HCTC recipient, but the election must also be made within six months after the initial loss of group health coverage. As a result, if the Employee finds out that he or she is eligible for this program with fewer than 60 days remaining in the six month period after initial loss of group health coverage, then this second election period will be less than 60 days. The Employee must send the COBRA Administrator a copy of the confirmation letter from HCTC or the State Workforce Agency, stating the effective date of eligibility under this program.~~

Amendment 21. Continued

SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)

At the time of a COBRA Qualifying Event, a Qualified Beneficiary has two primary options. The first is to waive his or her right to COBRA and make an election for coverage, whether group health coverage or insurance coverage through the individual market or the exchanges, in accordance with his or her HIPAA special enrollment rights. Please refer to the Special Enrollment section for further details. The second option is to elect COBRA continuation coverage. 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 as 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.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

Amendment 23

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 loss of coverage ~~as a result of active duty.~~ Employees on leave for military service must be treated like they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. 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 the military leave of absence cannot be subject to ~~Pre-Existing Conditions and~~ Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under 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 it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these 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 CONCURRENT

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 only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

Applies to Benefit Plan(s) 001, 002, 003, 004, 005

The word "**Network**" means an outside 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 fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, 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 which Network a provider belongs to will help a Covered Person to 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 need to see an In-Network provider, 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 which Network a provider belongs to, 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:

58 – United Healthcare Options PPO Network

- If a provider belongs to one of the following Networks, 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, but the providers have agreed to discount their fees. This means that the Covered Person may pay a little less for a particular claim than they would for an Out-of-Network claim.

XZ – First Health Shared Savings

- 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. These providers charge their normal rates for services, so Covered Persons may need to pay more. The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any.

Amendment 24: update

~~Effective: 07-11-2013 For Transplant Services at a Designated Transplant Facility the Preferred Provider Organization is:~~

OptumHealth

The program for Transplant Services at Designated Transplant Facilities is:

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. When Non-Network charges are covered in accordance with Network benefits, the charges are still subject to the Usual and Customary charge limitations. The following exceptions may apply:

- Covered Services provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist when services are provided at a Network facility or referred by an In-Network Physician, even if the provider is an Out-of-Network Provider.
- Covered Services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician 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 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.

1. **Abortions (Elective).**
2. **Allergy Treatment** including: injections, testing and serum.
3. **Ambulance Transportation:** Medically Necessary ground Ambulance Transportation by a vehicle designed, equipped and used only to transport the sick and injured to the closest facility for emergencies. Air ambulance is only covered in Emergency situations where serious danger to Your life or health may occur if You were transported by ground ambulance. Transportation from a Hospital or Skilled Nursing Facility to another location is generally not covered unless transportation in any other vehicle would endanger Your health. All ambulance suppliers must accept Medicare Assignment.
4. **Anesthetics and Their Administration** while You are in an Inpatient Hospital, or being treated on an Outpatient basis.
5. **Autism Spectrum Disorders (ASD) Treatment, when Medical Necessity is met.** Amendment 25

(ASD includes Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, Rett Syndrome and Pervasive Developmental Disorders).

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 prescribed and provided by a licensed healthcare professional practicing within the scope of their license ~~(if ABA therapy, preferably a Board Certified Behavior Analyst, BCBA).~~

~~If ABA Therapy meets Medical Necessity, frequency and duration will be subject to current UMR guidelines, for example ABA treatment up to 20 hours per week for 6 months. Treatment plans specific to ABA Therapy with goals progress and updates are required at least every 6 months for review of ongoing therapy to evaluate continued Medical Necessity.~~ delete paragraph

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).

Does not include services or treatment identified elsewhere in the Plan as noncovered or excluded (such as Investigational/Experimental or Unproven, custodial, nutrition-diet supplements, educational or services that should be provided through the school district).

6. **Blood (Applies to Benefit Plan(s) 006)** that You get on an Inpatient or Outpatient basis.
7. **Braces (Applies to Benefit Plan(s) 006)** for arms, legs, back and neck.
8. **Breast Prostheses (Applies to Benefit Plan(s) 006)** (including a surgical brassiere) after a mastectomy.
9. **Breast Pumps and related supplies.** Amendment 25 cont. Add to Breast Pump: Coverage is subject to Medical Necessity as defined by this Plan. Contact the Plan regarding limits on frequency, duration, or type of equipment that is covered.
10. **Breast Reductions** if Medically Necessary.
11. **Breastfeeding Support, Supplies and Counseling** in conjunction with each birth. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
12. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (see the Glossary of Terms) and when needed as a result of an Illness or Injury.
13. **Cardiac Rehabilitation** programs, if referred by a Physician, for patients who have:
 - had a heart attack in the last 12 months; or
 - had coronary bypass surgery; or
 - a stable angina pectoris.

Covered services include:

 - Phase I, while the Covered Person is an Inpatient.
 - Phase II, 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 (Applies to Benefit Plan(s) 001, 002, 003, 004, 005)** as well as protective lenses following such a procedure.
15. **Cataract or Aphakia Surgery (Applies to Benefit Plan(s) 006).** See also eye glasses.
16. **Chiropractic Treatment (Applies to Benefit Plan(s) 001, 002, 003, 004, 005)** by a Qualified chiropractor. Services for diagnosis by physical examination and plain film radiography, and when Medically Necessary for treatments for musculoskeletal conditions. Refer to "Maintenance Therapy" under the General Exclusions section of this SPD.
17. **Chiropractic Treatment (Applies to Benefit Plan(s) 006):** Manipulation of the spine to correct a subluxation.
18. **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.
19. **Cleft Palate And Cleft Lip,** including Medically Necessary oral surgery and pre-graft palatal expanders.

28. **Durable Medical Equipment (Applies to Benefit Plan(s) 001, 002, 003, 004, 005)** subject to all of the following:

- The equipment must meet the definition of Durable Medical Equipment as defined 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 is subject to review under the **Utilization Management Provision** of this SPD, if applicable.
- 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 growth of the person or 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;
 - > 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.

Replace word with: Care

29. **Durable Medical Equipment (Applies to Benefit Plan(s) 006):** The equipment must be prescribed by a Physician for use in Your home. Durable Medical Equipment must be durable, used for medical reason, and must not usually be useful to someone who is not sick or injured. DME items can only be obtained from a supplier who accepts Medicare assignment. The amount that You pay can vary. Medicare requires that some equipment be rented, and other equipment must be purchased. The type of Durable Medical Equipment that Medicare may cover includes, but is not limited to: Air fluidized beds, blood glucose monitors, commode chairs, crutches, home oxygen equipment and supplies, hospital beds, infusion pumps, nebulizers, patient lifts to lift patient from a bed or wheelchair, suction pumps, traction equipment, walkers, and wheelchairs.

30. **Emergency Room Hospital and Physician Services (Applies to Benefit Plan(s) 001, 002, 003, 004, 005)** 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.

31. **Emergency Room Hospital and Physician Services (Applies to Benefit Plan(s) 006)** when Your health is in serious danger. (Emergency services are generally not covered in foreign countries).

32. **Emergency Room Hospital and Physician Services Provided in a Foreign Country**, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

33. **Extended Care Facility Services (Applies to Benefit Plan(s) 001, 002, 003, 004, 005)** for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. Covered Person must obtain prior authorization for services in advance. (Refer to the **Utilization Management** section of this SPD). The following benefits are covered:

- Room and board.
- Miscellaneous services, supplies and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

Replace word with Care

ADD: Emergency Services Provided in a Foreign Country, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital or Physician services in a provider's office, as shown in the Schedule of Benefits.

48. **Laboratory Or Pathology Tests And Interpretation Charges** for covered benefits.
49. **Macular Degeneration (Applies to Benefit Plan(s) 006)** treatment for people with age-related macular degeneration. The treatment is referred to as ocular photodynamic therapy with verteporfin.
50. **Massage Therapy.** (See Therapy Services below)
51. **Maternity Benefits** for Covered Persons include:
- ~~Prenatal and postnatal care:~~
 - Hospital or Birthing Center room and board.
 - ~~Obstetrical fees for routine prenatal care.~~
 - Vaginal delivery or Cesarean section.
 - Medically Necessary diagnostic testing.
 - Abdominal operation for intrauterine pregnancy or miscarriage.
 - ~~Outpatient Birthing Centers:~~
 - Midwives.
- Add: Non-routine prenatal care.
Postnatal care.
52. **Mental Health Treatment (Applies to Benefit Plan(s) 001, 002, 003, 004, 005)** (Refer to Mental Health section of this SPD).
53. **Mental Health Treatment (Applies to Benefit Plan(s) 006)** needed on an Inpatient or Outpatient basis to help diagnose and treat mental health conditions, as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.
54. **Modifiers or Reducing Modifiers (Applies to Benefit Plan(s) 001, 002, 003, 004, 005)** if Medically Necessary, apply to services and procedures performed on the same day and may be applied to surgical, radiology and other diagnostic procedures. For providers participating with a primary or secondary network, claims will be paid according to the network contract. For providers who are not participating with a network, where no discount is applied, the industry guidelines are to allow the full 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.
55. **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.
- Gastric or intestinal bypasses. (Roux-en-Y; Biliopancreatic bypass; Biliopancreatic diversion with duodenal switch)
 - Stomach stapling. (Vertical banded gastroplasty; gastric banding; gastric stapling)
 - Lap band. (Laparoscopic adjustable gastric banding)
 - Gastric sleeve procedure. (Laparoscopic vertical gastrectomy; Laparoscopic sleeve gastrectomy)

This Plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions of this SPD.

70. **Prescription Drugs (Applies to Benefit Plan(s) 006)** if approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare Part A, Part B.
71. **Prescription Medications (Applies to Benefit Plan(s) 001, 002, 003, 004, 005)** which 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. This does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.
72. **Preventive / Routine Care (Applies to Benefit Plan(s) 001, 002, 003, 004, 005)** 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:

- Well-woman preventive care visit(s) for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other 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; and
- Screening and counseling for interpersonal and domestic violence.

Amendment 25 cont.

Please visit the following links for additional information:

~~<http://www.hrsa.gov/womensguidelines/>~~

Update: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>
or
<http://www.hrsa.gov/womensguidelines/>

73. **Private Duty Nursing Services** when Inpatient care is required 24 hours a day.
74. **Prosthetic Devices (Applies to Benefit Plan(s) 001, 002, 003, 004, 005).** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) which 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.

75. **Prosthetic Devices (Applies to Benefit Plan(s) 006)** needed to replace a body part or function, and as approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare.

76. **Qualifying Clinical Trials** as defined below. ~~Coverage does not include Phase I clinical trials (except as provided under the Clinical Trial Programs for Treatment of Pediatric Cancer).~~ Routine patient care costs as defined below Incurred during participation in a Qualifying Clinical Trial for the treatment of:

- Cancer.
- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip, and knees.
- Other diseases or disorders for which a clinical trial meets the Qualifying Clinical Trial criteria stated below.

see attached for amended language to this section

Clinical Trial Programs for Treatment of Pediatric Cancer: The majority of treatment for childhood cancer is provided within the context of a clinical trial. Covered services include routine patient care costs as defined below Incurred in connection with the provision of goods, services, and benefits to members who are Dependent Children in connection with Qualifying Clinical Trial programs as defined below for the treatment of Children's cancer, such as those by The National Cancer Institute (NCI)-sponsored Children's Oncology Group (COG).

For purposes of this provision, Pediatric is defined as eligible Children 0 - 18 years of age, unless treatment has been started prior to the Child's 19th birthday. Coverage does include Phase I clinical trials.

Qualifying Clinical Trial means, a trial in which all of the following criteria must be met:

- The trial must be sponsored and provided by a nationally recognized program or center that has been designated by any of the following:
 - National Institutes of Health (NIH) including 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);
 - National Comprehensive Cancer Network (NCCN);
 - Department of Defense (DOD); or
 - Veterans Administration (VA).
- 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 to confirm that the trial meets current standards for scientific merit and has the relevant IRB approvals; and
- 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.

Coverage for **routine patient care costs** for clinical trials include:

- Covered Health Services 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.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Coverage does **not include** the Experimental or Investigational Item or service that is the subject of the clinical trial.

Benefits include the reasonable and necessary items and services used to 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 clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

Amendment 25 cont.

Qualifying Clinical Trials as defined below, including routine patient care costs as defined below 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; and
- Cardiovascular disease (cardiac/stroke) that is not life threatening, for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below; and
- Surgical musculoskeletal disorders of the spine, hip and knees, that are not life threatening, for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below; and
- Other diseases or disorders that are not life threatening for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below.

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 (i.e., 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.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip, and knees and other diseases or disorders that are not life-threatening, a Qualifying Clinical Trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life threatening disease or disorder 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 the *Veteran's Administration (VA)*;
- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
- The *Department of Veterans Affairs*, the *Department of Defense*, 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 *National Institutes of Health*; 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.

Amendment 25 cont.

Qualifying Clinical Trials as defined below, including routine patient care costs as defined below 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; and
- Cardiovascular disease (cardiac/stroke) that is not life threatening, for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below; and
- Surgical musculoskeletal disorders of the spine, hip and knees, that are not life threatening, for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below; and
- Other diseases or disorders that are not life threatening for which the Plan determines a clinical trial meets the Qualifying Clinical Trial criteria stated below.

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 (i.e., 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.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip, and knees and other diseases or disorders that are not life-threatening, a Qualifying Clinical Trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life threatening disease or disorder 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 the *Veteran's Administration* (VA);
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
 - The *Department of Veterans Affairs*, the *Department of Defense*, 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 *National Institutes of Health*; 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.

HOME HEALTH CARE BENEFITS

Applies to Benefit Plan(s) 001, 002, 003, 004, 005

when Medically Necessary

Home Health Care services are provided for patients ~~who are unable to leave their home~~, as determined by the Utilization Review Organization. Covered Persons must obtain prior authorization ~~in advance~~ before receiving services. Please refer to the ~~Utilization Management~~ section of this SPD for more details. Covered services can include:

replace word with Care

- Home visits instead of visits to the provider's office that do not exceed the Usual and Customary charge to perform the same service in a provider's office.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a registered dietitian.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a therapist or a registered dietician.

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.

Benefits are payable for the following transplants:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by utilization management.
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous) for certain conditions.
- Small bowel.

replace word with Care

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 transplant facility, the Plan will allow them 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 and supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS (Applies to a Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to a Covered Person who is a recipient or to a covered or non-covered donor if the recipient is a Covered Person under this Plan)

If the Covered Person or non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing, 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.
 - Tolls and parking fees.
 - Gas/mileage.
- Lodging at or near the transplant facility including:
 - Apartment rental.
 - Hotel rental.
 - Applicable tax.

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 shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

Note: This Plan will only pay travel and housing benefits for a non-covered living donor after any other coverage that the living donor has is exhausted.

PRESCRIPTION DRUG BENEFITS

Applies to Benefit Plan(s) 001, 002, 003, 004, 005

What this section includes:

Amendment 28

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order service for obtaining Prescription Drugs;
- Any benefit limitations and exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Benefits.

Prescription Drug Benefit Highlights

Prescription Drug Benefits will not be coordinated with those of any other health coverage plan. ~~Any pre-existing provisions of this plan do not apply to Prescription Drug Benefits.~~

Identification Card (ID Card) – Network Pharmacy

You must either show Your ID card at the time You obtain Your Prescription Drug at a Network Pharmacy or provide the Network Pharmacy with identifying information that can be verified by OptumRx during regular business hours.

If You don't show Your ID card or provide verifiable information at a Network Pharmacy, You will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

Benefit Levels

Benefits are available for outpatient Prescription Drugs that are considered a Covered Expense.

The Plan pays benefits at different levels for tier 1, tier 2 and, if applicable, tier 3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug can change periodically, as frequently as monthly, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, You may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, for the most current information, You can visit www.UMR.com, and navigate to the myPharmacyCenter section, or call OptumRx at 877-559-2955.

Each tier is assigned a Co-pay or Participation, which is the amount You pay when You visit the pharmacy or order Your medications through mail order. Your Co-pay or Participation will also depend on whether or not You visit the pharmacy or use the mail order service; see the Prescription Schedule of Benefits for further details. Here's how the tier system works:

Tier 1 is Your lowest Co-pay or Participation option. For the lowest out-of-pocket expense, You should consider tier 1 drugs if You and Your Physician decide they are appropriate for Your treatment.

Tier 2 is Your middle Co-pay or Participation option. Consider a tier 2 drug if no tier 1 drug is available to treat Your condition.

Tier 3, if applicable, is Your highest Co-pay or Participation option. The drugs in tier 3 are usually more costly. Sometimes there are alternatives available in tier 1 or tier 2.

For Prescription Drugs at a retail Network Pharmacy, You are responsible for paying the lower of:

- The applicable Co-pay, Participation, or Deductible amount;
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- The Prescription Drug Charge that OptumRx agreed to pay the Network Pharmacy.

COVERED BENEFITS - What the Prescription Drug Benefits Section Will Cover

The following are considered Covered Expenses:

Add: Vaccines. Some vaccines may be covered, and may have limitations depending on whether the vaccine is administered in a pharmacy or a clinic.

- **Prescription products which are:**
 - Necessary for the care and treatment of an Illness or Injury and are prescribed by a duly licensed medical professional; and
 - Can be obtained only by Prescription and are dispensed in a container labeled "Rx only"; and
 - The following non-prescription products prescribed by a duly licensed medical professional:
 - Compounded medications of which at least one ingredient is a Prescription Drug;
 - Any other medications which due to state law may only be dispensed when prescribed by a duly licensed medical professional; and
 - In an amount not to exceed the day's supply outlined in the Prescription Schedule of Benefits.
- **Prescription Drugs lost as a direct result of a natural disaster.** Covered Persons will be given the opportunity to prove that Prescription Drugs otherwise considered Covered Expenses under this Plan were lost due to a natural disaster. Acceptable proof could include, but not necessarily be limited to, proof of other filed claims of loss (homeowner's, property, etc.).
- **Mail Order Prescriptions.** The Plan will pay for Covered Expenses Incurred by a Covered Person for Prescription products dispensed through the mail order pharmacy identified by OptumRx. Prescription products may be ordered by mail with a Co-pay from the Covered Person for each Prescription or refill. The Co-pay is shown on the Prescription Schedule of Benefits. By law, Prescription products cannot be mailed to a Covered Person outside the United States.
- **Diabetic Supplies.** Some diabetic supplies may be covered.

Covered Expenses apply to only certain Prescription Drugs and supplies. You can visit www.UMR.com, and navigate to the myPharmacyCenter section, or call OptumRx at 877-559-2955, for information on which specific Prescription Drugs and supplies are covered.

EXCLUSIONS - What the Prescription Benefits Section of this Plan Will Not Cover

In addition, the following exclusions apply.

When an exclusion applies to only certain Prescription Drugs, You can visit www.UMR.com, and navigate to the myPharmacyCenter section, or call OptumRx at 877-559-2955 for information on which Prescription Drugs are excluded.

Excluded medications are:

- For any condition, Injury, sickness or Mental Health Disorder arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;
- Any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
- Pharmaceutical products for which benefits are provided in the medical (not in the Prescription Drug Benefits) portion of the Plan;

Add: Tobacco cessation products;

Generic means a Prescription Drug that is either:

- Chemically equivalent to a Brand-name drug; or
- Identified by OptumRx as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.
- You should know that all products identified as "Generic" by the manufacturer, pharmacy, or Your Physician may not be classified as Generic by OptumRx.

Network Pharmacy means a retail or mail order pharmacy that has:

- Entered into an agreement with OptumRx to dispense Prescription Drugs to Covered Persons;
- Agreed to accept specified reimbursement rates for Prescription Drugs; and
- Been designated by OptumRx as a Network Pharmacy.

PDL: see Prescription Drug List (PDL).

Pharmacy and Therapeutics P&T Committee means the committee that OptumRx designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Prescription Drug means a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, only be dispensed using a Prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs also include:

- Inhalers (with spacers);
- Insulin;
- The following diabetic supplies:
 - Insulin syringes with needles;
 - Blood-testing strips - glucose;
 - Urine-testing strips - glucose;
 - Ketone-testing strips and tablets;
 - Lancets and lancet devices;
 - Insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets;
 - and
 - Glucose monitors.

Amendment 30

Delete semi-colon

Prescription Drug Charge means the rate OptumRx has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL) means a list that categorizes into tiers medications, products, or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to periodic review and modification (as frequently as monthly). You may determine to which tier a particular Prescription Drug has been assigned by visiting www.UMR.com, and navigating to the myPharmacyCenter section, or calling OptumRx at 877-559-2955.

Therapeutic Class means a group or category of Prescription Drug with similar uses and/or actions.

Therapeutically Equivalent means when Prescription Drugs have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge, also known as the retail price, means the amount charged to customers who have no health coverage for Prescription Drugs.

MENTAL HEALTH BENEFITS

Applies to Benefit Plan(s) 001, 002, 003, 004, 005

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, Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Amendment 32

Inpatient Services are payable subject to all of the following:

- The Hospital or facility must be 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 or licensing body working in that foreign country.
- This Plan also covers services provided at a residential treatment facility that is licensed by the state in which it operates and provides treatment for Mental Health Disorders. There is an MD/psychiatrist on staff. This does not include services provided at a group home. Treatment in a residential treatment facility is not for the purpose of providing custodial care. If outside the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.
- ~~The Covered Person must have the ability to accept treatment.~~
- The Covered Person must be ill in more than one area of daily living to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the Covered Person's condition would deteriorate.
- The Covered Person's Mental Health Disorder must be treatable in an Inpatient facility.
- The Covered Person's Mental Health Disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside the United States, the Covered Person's Mental Health Disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region.
- The attending Physician must be a psychiatrist. If the admitting Physician is not a psychiatrist, a psychiatrist must attend to the Covered Person within 24 hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside the United States, Inpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally 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 programs must be a less restrictive alternative to Inpatient treatment.

SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY BENEFITS

Applies to Benefit Plan(s) 001, 002, 003, 004, 005

The Plan will pay the following Covered Expenses for a Covered Person subject to any Deductibles, Co-pays if applicable, Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, the Usual and Customary amount, or the Negotiated Rate as applicable.

COVERED BENEFITS

Inpatient Services are payable subject to all of the following:

- The Hospital or facility must be 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 abuse and chemical dependency. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.
- This Plan also covers services provided at a residential treatment facility that is licensed by the state in which it operates and provides treatment for substance abuse and chemical dependency disorders. This does not include services provided at a group home. If outside the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.
- ~~The Covered Person must have the ability to accept treatment.~~ Amendment 33. delete sentence
- The Covered Person must be ill to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the Covered Person's condition would deteriorate.
- The Covered Person's condition must be treatable in an Inpatient facility.
- The Covered Person's condition must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the Covered Person's condition must meet diagnostic criteria established and commonly recognized by the psychiatric community in that region.

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such programs must be a less restrictive alternative to Inpatient treatment.

Outpatient Services are payable subject to all of the following:

- Must be in person at a therapeutic medical facility; and
- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and

**UTILIZATION MANAGEMENT
And Other Medical Management Services**

Amendment 34
Delete entire section and
replace with attached

Applies to Benefit Plan(s) 001, 002, 003, 004, 005

Utilization Management is the process of evaluating whether services, supplies or treatment are Medically Necessary and are appropriate to help ensure cost-effective 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.

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. Covered Persons should call 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 fact gathering and independent medical review, if necessary.

Special Note: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

This Plan complies with the Newborns and Mothers Health Protection Act. The Prior Authorization requirement is not required for Hospital or Birthing Center stays 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 stays beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR CARE MANAGEMENT**

DEFINITIONS

The following terms are used for the purpose of the Utilization Management section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Prior Authorization is the process of determining benefit coverage prior to service being rendered to an individual member. A determination is made based on Medical Necessity criteria for services, tests or procedures 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.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the effectiveness and appropriateness of health care services and treatment plans. Such assessment can 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 Management Organization **before** receiving services for the following:

- Inpatient stay in a Hospital or Extended Care Facility.
- Organ and tissue transplants.
- Home Health Care.

- Durable Medical Equipment over \$1,500 or any Durable Medical Equipment rentals over \$500/month.
- Prosthetics over \$1,000.
- All Inpatient stays for Mental Health Disorders, substance abuse and chemical dependency and residential treatment facility.
- Inpatient stay in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.
- Clinical trials.

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).

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 of \$250 will be applied to applicable claims if a Covered Person receives services but did not obtain the required Prior Authorization for:

- Inpatient stay in a Hospital or Extended Care Facility.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment over \$1,500 or any Durable Medical Equipment rentals over \$500/month.
- Prosthetics over \$1,000.
- All Inpatient stays for Mental Health Disorders, substance abuse and chemical dependency and residential treatment facility.
- Inpatient stay in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.

The phone number to call for Prior Authorization is listed on the back of the Plan Identification card.

Even though a Covered Person provides Prior Authorization from the Utilization Review Organization, that does not guarantee that this Plan will pay for the medical care. The Covered Person still needs to be eligible for coverage on the date services are provided. Coverage is also subject to all of the provisions described in this SPD.

Medical Director Oversight. A UMR 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 appropriateness using evidence-based clinical criteria.

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. These triggers include ICD-9 diagnosis codes, CPT codes and length-of-stay criteria, as well as specific criteria requested by the Plan Administrator. Information is easily passed from Utilization Management to case management through our fully-integrated care management software system.

All Prior Authorization requests are used to identify the member's needs. 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 is conducted by Plan Administrator request as long as the request is received within 30 days of the original determination. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures.

Other Medical Management Services

Maternity Management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full term-deliveries and decreases the cost of a long term hospital stay for both the mother and/or baby. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment to determine the member's risk level and educational need is done at that time. To increase participation, the program uses incentives to participate. The standard incentive is a gift card. Covered Persons who enroll via the web receive a special edition pregnancy information guide. UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they're pregnant. Members self-enroll in the pre-pregnancy coaching program by calling our toll-free number. They are then contacted by a nurse case manager who has extensive clinical background in obstetrics/gynecology. The nurse completes a pre-pregnancy assessment to determine risk level, if any, and provides them with education and materials based on their needs. The nurse also helps members understand their Plan's benefit information.

Case Management Services are designed to identify catastrophic and complex illnesses, transplants and trauma cases. UMR Care Management's case management specialists identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified from the Prior Authorization review process, national criteria and system flags based on ICD-9 diagnosis, CPT procedure code and potential high dollar claim criteria. UMR Care Management works directly with the patient, family members, treating Physician and facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious illness helps avoid major complications in the future. The Covered Person can request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

NurseLine service is a 24/7 health information line that assists Covered Persons with medical-related questions and concerns. NurseLine gives Covered Persons access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their Dependents.

Amendment 34 Add entire section

CARE MANAGEMENT

Utilization Management

Utilization Management is the process of evaluating whether services, supplies or treatment is Medically Necessary and appropriate to help ensure cost-effective 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.

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. Covered Persons should call 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 fact-gathering and independent medical review, if necessary.

Special Notes: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who have received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or after Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

This Plan complies with the Newborns and Mothers Health Protection Act. Prior Authorization is not required to certify Medical Necessity 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: **UMR CARE MANAGEMENT**

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 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 services, tests or procedures 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.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the Medical Necessity, effectiveness and appropriateness of health care services and treatment plans. 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.
- Partial hospitalizations.

- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, over \$1,500 or any Durable Medical

Equipment rentals over \$500/month.

- Prosthetics over \$1,000.
- Qualifying Clinical Trials.
- Inpatient stays in a Hospital or Birthing Center that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.

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).

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 of \$250 will be applied to applicable claims if a Covered Person receives services but does not obtain the required Prior Authorization for:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, over \$1,500 or any Durable Medical Equipment rentals over \$500/month.
- Prosthetics over \$1,000.
- Qualifying Clinical Trials.
- Inpatient stays in a Hospital or Birthing Center that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.

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.

Medical Director Oversight. A UMR 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.

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. Case management opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points including the following criteria: length of stay, level of care, readmission and utilization, as well as employer or self-referrals. Information is easily passed from Utilization Management to case management through our fully-integrated care

management software system.

All Prior Authorization requests are used to identify the member's needs. 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 is conducted by Plan Administrator request as long as the request is received within 30 days of the original determination. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures.

Maternity Management

Maternity Management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of a long term hospital stay for both the mother and/or baby. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment is performed at that time to determine the member's risk level and educational needs. The program uses incentives in order to increase participation. The standard incentive is a gift card. Covered Persons who enroll via the web receive a special edition pregnancy information guide. UMR's pre-pregnancy

coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they're pregnant. Members self-enroll in the pre-pregnancy coaching program by calling our toll-free number. They are then contacted by a nurse case manager who has extensive clinical background in obstetrics/gynecology. The nurse completes a pre-pregnancy assessment to determine risk level, if any, and provides them with education and materials based on their needs. The nurse also helps members understand their Plan's benefit information.

Case Management

Case Management services are designed to identify catastrophic and complex illnesses, transplants and trauma cases. UMR Care Management's nurse case managers identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly inpatient stays. Opportunities are identified by using a system-integrated,

automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission and utilization, as well as employer or self-referrals. UMR Care Management works directly with the patient, the patient's family members, the treating Physician and the facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious illness helps avoid major complications in the future. The Covered Person may request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

NurseLine

NurseLine service is a health information line that is available 24 hours per day, seven days a week that assists Covered Persons with medical-related questions and concerns. NurseLine gives Covered Persons access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their Dependents.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. 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. When a Covered Person has coverage under this Plan as both an Employee and a Dependent, then this Plan will internally coordinate benefits. **(Applies to Benefit Plan(s) 001, 002, 003, 004, 005)** Prescription drug coverage will be coordinated under this Plan. **(Applies to Benefit Plan(s) 006)** Prescription drug coverage under Medicare Part D will be coordinated under the Medicare Secondary Payer Rules. 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 (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 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:

Amendment 35

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of \$200 per day.
- Specified disease policies.
- 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. See order of benefit determination rules (below) for details.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law. See below. This does not include Medicaid.

ADD: This Plan does not, however, 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 shall 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 to use:

- The plan that has no coordination of benefits provision is considered primary.
- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.

Amendment 35 cont.

ADD: 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.

Amendment 36

34. **Foot Care (Podiatry):** Routine foot care.

See below for update

35. ~~Foreign Coverage for Medical Care Expenses~~, except for Emergency room Hospital and Physician services, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

36. **Genetic Counseling** other than based on Medical Necessity unless covered elsewhere in this SPD.

37. **Genetic Testing** unless covered elsewhere in this SPD.

38. **Growth Hormones:** **Foreign Coverage for Medical Care Expenses, Which Includes Preventive Care or Elective Treatment**, except for services that are Incurred in the event of an Emergency. Emergency room Hospital and Physician services, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital, or

39. **Hearing Services:**

Physician services In a provider's office, as shown in the Schedule of Benefits.

- Purchase or fitting of hearing aids.
- Implantable hearing devices unless covered elsewhere in this SPD.

40. **Home Births** and associated costs.

41. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steambaths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.

42. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.

43. **Infertility Treatment:**

- Fertility tests.
- Surgical reversal of a sterilized state which was a result of a previous surgery.
- 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.
- Freezing or storage of embryo, eggs, or semen.
- Genetic testing.

This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition, slow the harm to, alleviate the symptoms, or maintain the current health status of the Covered person.

44. **Lamaze Classes** or other child birth classes.

45. **Lasik Surgery, Radial Keratotomy, Refractive Keratoplasty (Applies to Benefit Plan(s) 006)** or similar surgery used to improve eye sight or refractive disorders.

46. **Learning Disability:** Non-medical treatment, including but not limited to special education, remedial reading, school system testing and other 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.

47. **Liposuction** regardless of purpose.

- ~~68. **Pre-Existing Conditions** exclusions, as specified in the **Pre-Existing Conditions Exclusion** section.~~
69. **Preventive / Routine Care Services** unless covered elsewhere in this SPD.
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 completion of claim forms or forms necessary for the return to work or school.
72. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.
73. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.
74. **Self-Administered Services** or procedures that can be done by the Covered Person without the presence of medical supervision.
75. **Self-Inflicted** unless due to a medical condition (physical or mental) or domestic violence.
76. **Services at no Charge or Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or 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.
77. **Services** that should legally be provided by a school.
78. **Services Provided by a Close Relative.** See Glossary of Terms of this SPD for definition of Close Relative.
79. **Sex Therapy.**
80. **Sex Transformation:** Treatment, drugs, medicines, services and supplies for, or leading to, sex transformation surgery.
81. **Sexual Function:** Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence.
82. **Skilled Nursing Care (Applies to Benefit Plan(s) 006):** Any Skilled Nursing Facility services which exceed the appropriate level of skill required for treatment as determined by the Plan.
83. **Standby Surgeon Charges.**
84. **Subrogation.** Charges for Illness or Injuries 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 Subrogation section. See the Subrogation section for more information.
85. **Surrogate Parenting and Gestational Carrier Services,** including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.

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 Claims Administrator, on behalf of the Plan, prior to services being provided. Although not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. Covered Persons or providers may wish to request a Pre-Determination before incurring medical expenses. A Pre-Determination is not a claim and therefore cannot 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

Amendment 38

- **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 is required to get approval from the Plan *before* obtaining the medical care such as in the case of prior authorization of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan just to find out if a claim will be covered, that is not a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization (See Pre-Determination above). Giving prior authorization does not guarantee that the Plan will ultimately pay the claim.

Replace word
with Care

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 **Utilization Management** section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation when a sudden and serious condition such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of his or her 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 can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. Minor Dependents must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

replace with: proper documentation

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit a ~~written letter~~ 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 ~~their~~ Personal Representative access to their Protected Health Information. This letter must be signed by the Covered Person to be considered official.

replace with: his or her

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 correct. For any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted.

Note: For Prescription benefits, Covered Persons will receive an EOB when a Covered Person files a claim directly with OptumRx. ~~Benefits received or denied at the point of sale in the Pharmacy are not considered claims.~~ See Procedures For Submitting Claims for more information.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although the Covered Person may voluntarily extend these timelines:

- Pre-Service Claim: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan can 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 can 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 Claim: 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.

Amendment 39

Medical Necessity

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 can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- 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.

- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Usual and Customary fee limits, fee schedule or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- 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 can 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 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 was 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/her Personal Representative can 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 any outside action is taken.

- Covered Persons must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume that Covered Persons received the EOB form five days after the Plan mailed the EOB form.
- Covered Persons or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.

Amendment 38 cont

Add: 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 You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would 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, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

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.

- Covered Persons who are not satisfied with the decision following the first appeal have the right to appeal the denial a second time.
- Covered Persons or their Personal Representative must submit a written request for a second review within 60 calendar days following the date received the Plan's decision regarding the first appeal. The Plan will assume that Covered Persons received the determination letter regarding the first appeal five days following the date the Plan sends the determination letter.
- Covered Persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their 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, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

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 their rights to any other benefits under the Plan. For any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (Personal Representative) or other details, please contact the Plan.

Amendment 38 cont

Add: 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 You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

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 FMLA, Your employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid; and
- The Employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

Amendment 40

An Employee ~~can~~ ^{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, ~~and no new pre-existing requirements will be imposed.~~ 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 of the written procedures, at no charge, 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 (e.g., Your Physician, nurse, or midwife, or a 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.

**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 shall 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 shall 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 which it performs on behalf of this Plan.

This Plan agrees that it will only Disclose a Covered Person's PHI to the Plan Sponsor 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 only Use and Disclose a Covered Person's PHI (including Electronic PHI) 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 to 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; Amendment 41
- The Plan Sponsor will promptly report to this Plan any impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents; breach or impermissible
- The Plan Sponsor will report to the Plan any security incident with respect to Electronic PHI of which Plan Sponsor becomes aware; breach or

ADD: 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;

Amendment 42

Amendment 45

~~Creditable Coverage means a certificate or other documentation that is provided to a person upon losing health care coverage. The certificate or other documentation specifies how much Creditable Coverage a person has and is used to reduce the length of a Pre-Existing Condition exclusion period under a Plan.~~

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a step Child; 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 You, Your spouse, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, Children, step Children and grandchildren.

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 a Qualifying Event.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits.

Cosmetic Treatment means medical or surgical procedures which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expense means any expense, or portion thereof, which 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.

~~Creditable Coverage means coverage an individual has under the following as defined by federal law and applicable regulations:~~

- A group health plan;
- Health insurance coverage (through a group or individual policy);
- Medicare;
- Medicaid;
- A medical care program of the uniformed services;
- A medical care program of the Indian Health Services or of a tribal organization;
- A state health benefits risk pool;
- A state Children's Health Insurance Program;
- A health plan offered under the Federal Employee Health Benefits Program;
- A public health plan, including any plan established or maintained by a state, the U.S. government, a foreign country or any political subdivision of the same; or
- A health benefit plan under Section 5(e) of the Peace Corps Act.

Amendment 45 cont.

~~Creditable Coverage shall not include coverages for liability, disability income, limited scope dental or vision benefits, specified disease, supplemental benefits and other excepted benefits as defined by federal law and applicable regulations. A period of Creditable Coverage shall not be counted, with respect to enrollment under a group health plan, if there is a 63-day lapse in coverage between the end of the prior coverage and the beginning of the person's enrollment under this Plan.~~

Custodial Care means nonmedical care given to a Covered Person to administer medication and to assist 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 healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

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 the work gets done. 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 shall be made consistent with Section § 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs which are intended to promote fertility, achieve a condition of pregnancy, or treat an illness causing an infertility condition when such treatment is done 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 done to prepare for induced conception; surgical reversal of a sterilized state which 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 which 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. 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 or in a Hospital for 24 hours or more. A person is not an 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.

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.

Limiting Charge means the highest amount of money You can be charged for a covered service by Physicians and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The Limiting Charge only applies to certain services and does not apply to supplies or equipment.

Lifetime Reserve Days means the 60 days that Medicare will pay for when the Covered Person is in a Hospital more than 90 days during a Benefit Period. These 60 reserve days can be used only once during the Covered Person's lifetime. For each Lifetime Reserve Day, Medicare will pay all covered costs except for the daily coinsurance amount.

Maximum Benefit means the maximum amount or the maximum number or days or treatments that are considered a Covered Expense by the Plan.

Amendment 44

Add: Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Multiple Surgical Procedures means when more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept a payment in full for Covered Expenses of the Plan.

Non-Essential Health Benefit means any medical benefit that is not an Essential Health Benefit. Please refer to the "Essential Health Benefit" definition.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, 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 Appliances means braces, splints, casts and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is 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 room and board charges are not Incurred.

Outpatient Prospective Payment System means the system that Medicare uses to pay for services that the Covered Person receives at a Hospital, community mental health center and other facilities as an Outpatient.

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 preventative 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.

Participating Pharmacy means a licensed entity, acting within the scope of their license in the state in which they dispense, that has entered into a written agreement with OptumRx and has agreed to provide services to covered individuals for the fees negotiated in the agreement.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT), a physician's assistant (PA), a nurse practitioner (NP), a certified nurse midwife (CNM), or a certified registered nurse anesthetist (CRNA). The term Physician also may include, at the Plan Sponsor's discretion, other licensed practitioners who are regulated by a state or federal agency, who perform services payable under this Plan, and who are acting within the scope of their license, unless specifically excluded by this Plan.

Placed or 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 SWEETWATER COUNTY 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.

Amendment 44 cont.

ADD: Pediatric Services means services provided to individuals under the age of 19.

~~Pre-Existing Condition means an illness or injury for which medical advice, diagnosis, care, or treatment was recommended or received within the timeframe specified in the Pre-Existing Condition Provision section of this document.~~

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 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 recommendations of the Center 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.

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 or certified by the state in which the provider practices.

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 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.

~~Significant Break in Coverage means a period of 63 consecutive days during which a person does not have any Creditable Coverage.~~

Amendment 45 cont.

Skilled Nursing Facility Care means an institution that has a transfer agreement with one or more Hospitals. For the most part, it provides inpatients with skilled nursing care and related services. The facility must be licensed by the state in which it operates as a Skilled Nursing Facility. Any service that could be safely done by an average non-medical person (or by one's self) without the supervision of a registered nurse is not considered skilled care.

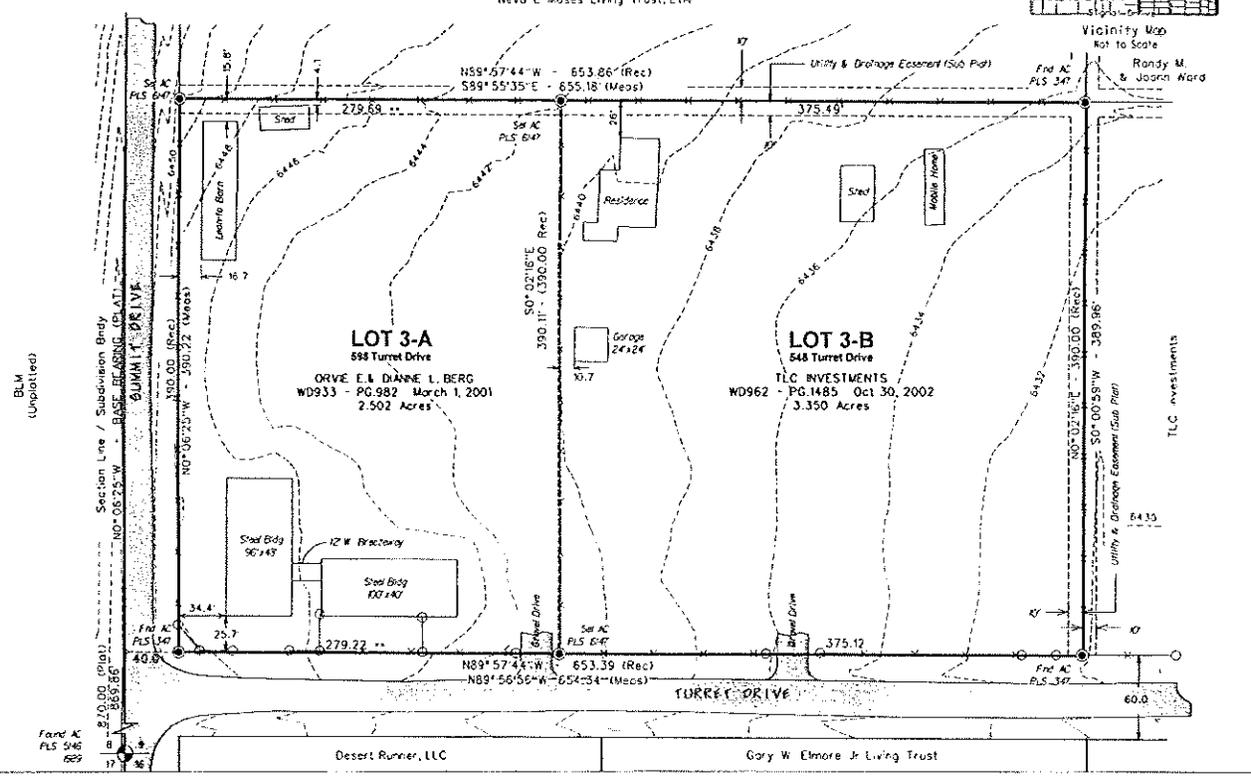
Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services 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.

BOARD OF COUNTY COMMISSIONERS MEETING REQUEST FORM

Date Requested: 12/2/14	Name & Title of Presenter: Steve Horton, Planner III
Department or Organization: Land Use Department	Contact Phone & E-mail: 872-3914
Exact Wording for Agenda: Simple Land Division for Orvie Berg and TLC Investments	Preference of Placement on Agenda & Amount of Time Requested for Presentation: Morning/5 minutes
Will there be Handouts? (If yes, include with meeting request form) Yes	Will handouts require SIGNATURES: Yes
Additional Information: Orvie Berg and TLC Investments are seeking approval of the Simple Land Division for Lot 3 of Mountaineer Subdivision Amended 4th Section. Lot 3-A will be owned by Orvie Berg and Lot 3-B will be owned by TLC Investments. Both lots are zoned Commercial and are being used for mining-drilling-oilfield service uses.	

- All requests to be added to the agenda will need to be submitted in writing on the "Meeting Request Form" by Wednesday at 12:00 p.m. prior to the scheduled meeting and returned in person or electronically to Clerk Sally Shoemaker at: shoemakers@sweet.wy.us
- All handouts are also due by Wednesday at 12:00 p.m. prior to the scheduled meeting date. Handouts may be submitted to Clerk Sally Shoemaker either in person or electronically. *****If your handout is not accompanied with the request to be added to the agenda, your request will be dismissed and you may reschedule for the next meeting provided the handout(s) are received.*****
- Any documents requiring **Board Action** or **signature** are considered agenda items and need to be requested in the same manner.
- All **original** documents requesting action or signature must be submitted to Deputy County Clerk Vickie Eastin. However, a **copy** must be submitted to Sally Shoemaker for distribution of the packet and retention.
- As always, if you are unable to attend the meeting after being placed onto an agenda, please send a representative in your place or your item will be rescheduled.
- In order to determine placement on the agenda, please review the county website (www.sweet.wy.us/commissioner) on Thursday afternoon.
- If a request to be placed on an agenda is received **AFTER** the deadline, you will be considered for the next meeting date.
- No handout will be received during a meeting in session.



Applicant's Statement of Submittal

Lot 3-A

I/We, the present owners of Lot 3-A, as shown herein, hereby submit this instrument for filing in the Office of the Sweetwater County Clerk on this 22 day of May, 2012.

Orve E. Berg *Dianne L. Berg*

Notary Statement

State of Wyoming,)
 County of Sweetwater)

LUCKEITERS
 Notary Public
 State of Wyoming
 County of Sweetwater
 My Commission Expires
 April 18, 2014

The foregoing instrument was acknowledged before me by Orve & Dianne Berg this 22 day of May, 2012.

Sandra Lewis
 Notary Public

My Commission Expires: 4-18-2014

Lot 3-B

I/We, the present owners of Lot 3-B, as shown herein, hereby submit this instrument for filing in the Office of the Sweetwater County Clerk on this 22 day of May, 2012.

Troy A. Clark *Lynn Clark*

Notary Statement

State of Wyoming,)
 County of Sweetwater)

JENNIFER BERG, Notary Public
 COUNTY OF SWEETWATER STATE OF WYOMING
 MY COMMISSION EXPIRES MARCH 2014

The foregoing instrument was acknowledged before me by Troy & Lynn Clark this 22 day of May, 2012.

Jennifer Berg
 Notary Public

My Commission Expires: 3-28-2014

Legal Descriptions

Lot 3-A

A portion of Lot Three (3) of the Mountaineer Subdivision, Amended Fourth Section, being more particularly described as follows: Beginning at the Southwest corner of said Lot 3; Thence S 89°57'44"E along the South line of said Lot 3 for a distance of 279.22 feet; Thence N 0°02'16"E for a distance of 390.00 feet to a point on the northerly line of said Lot 3; Thence N 89°57'44"W along the said northerly line of Lot 3 for a distance of 279.69 feet to the Northwest corner thereof; Thence S 0°06'25"E along the westerly line of said Lot 3 for a distance of 390.00 feet to the point of beginning. Containing 2.502 Acres, more or less.

Lot 3-B

All of Lot Three (3) of the Mountaineer Subdivision, Amended 4th Section, EXCEPTING THEREFROM the following described parcel: Beginning at the Southwest corner of said Lot 3; Thence S 89°57'44"E along the South line of said Lot 3 for a distance of 279.22 feet; Thence N 0°02'16"E for a distance of 390.00 feet to a point on the northerly line of said Lot 3; Thence N 89°57'44"W along the said Northerly line of Lot 3 for a distance of 279.69 feet to the Northwest corner thereof; Thence S 0°06'25"E along the westerly line of said Lot 3 for a distance of 390.00 feet to the point of beginning. Containing 3.350 Acres, more or less.

Certificate of Surveyor

I, Kent E. Felderman, hereby certify that I am a Professional Land Surveyor, registered under the laws of the State of Wyoming, employed by LEGEND SERVICES, P.C. to perform a boundary survey and that this map accurately shows the results of said survey as performed by me or under my direct supervision, commencing on the 15th day of April, 2012.



Legend

- Lot 3 Boundary
- - - Lot Division Line
- - - Elevation Contour 12ft Interval
- Chain Link Fence
- Section Corner Found
- Num. Cop Property Corner

Miscellaneous Notes

PUBLIC NOTICE - ANY FURTHER DIVISION OF EITHER PARCEL DESCRIBED ON THIS MAP SHALL REQUIRE FULL COMPLIANCE WITH ALL SUBDIVISION REGULATIONS OF SWEETWATER COUNTY.

The Base bearing for this survey is referenced to the west line of Section 9, T19N, R05W between found monuments at the southwest section corner and the west quarter corner thereof.

All bearings and distances shown herein were measured during the course of the survey except as otherwise indicated. The symbol "x" signifies measured and record values are certified.

Rocky Mountain Survey, Inc.
 Rock Springs, WY 82901
 (307)-382-2212

Surveying & Mapping Services, GIS Development
 Licensed in Wyoming, Colorado & Utah

County Approval

This map is hereby officially approved and recommended for filing in the Office of the Sweetwater County Clerk.

Sweetwater County Land Use Director _____ Date _____

Sweetwater County Board of Commissioners Chairman _____ Date _____

SIMPLE LAND DIVISION

Lot 3, Mountaineer Subdivision
 4th Section Amended
 Located in Section 9,
 Township 19 North, Range 105 West,
 6th P.M., Sweetwater County, Wyoming