Volusia County
FLORIDA

Health Partnership Plan

Medical and Prescription Drug Coverage

For Schedule of Benefits, See Pages 1, 2 & 3

Summary Plan Description

Revised Effective: May 1, 2016

Group No. 2081

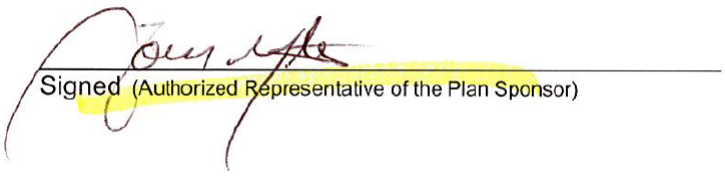
PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

PLEASE SIGN BELOW TO ACKNOWLEGDE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM TO:

HealthSmart
PO Box 91607
Lubbock, TX 79490-1607

We, the Plan Sponsor, recognizes that we have full responsibility for the contents of the Plan Document and that, while the Contract Administrator (its Employees and/or subcontractors) may have assisted in the preparation of the document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our Employee Welfare Benefit Plan.

Plan Sponsor/Plan Administrator: County of Volusia



Signed (Authorized Representative of the Plan Sponsor)

4/22/16
Date

ADOPTION OF THE PLAN DOCUMENT

Adoption
Plan Sponsor hereby adopts this Plan Document as the written description of its Employee Welfare Benefit Plan (the "Plan"). This Plan Document replaces any prior statement of the health care Coverage's of the Plan and is effective on the date shown below.

Purpose of the Plan
The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan include:

- Medical Care Coverage (Hospital, Physician Services, etc.)
- Prescription Drug Coverage

Conformity with Law
If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Participating Employers
Employers participating on this Plan are as stated in the section entitled General Information.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

Acceptance of the Plan Document
IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed effective as of January 1, 2016.

COUNTY OF VOLUSIA

Date: 4/22/16

By: _____
Signature

Tom Yokes, Human Resources Director
Print Name & Title of Signatory

Health Partnership Plan (HPP) Contact Information

Claims Information & Plan Inquiries

HealthSmart
Benefit Solutions
PO Box 91607
Lubbock, TX 79490-1607 (855) 224-5173

Volusia County Personnel Division (Insurance-Benefit)

Personnel Main Number (386) 736-5951

Website: http://volusia.org/personnel/benefits or http://enn.co.volusia.fl.us/

Medical Pre-certification Requirements

24-HOUR NURSE HELP LINE
(877) 582-7061

KePRO Pre-certification (888) 522-7742

You must pre-certify with KePRO the following procedures before services are rendered by your provider in order to avoid a penalty.

In-patient Hospital Stay – call 7 days prior to admission or the next working day after an emergency admission.

Outpatient surgical and medical services which require pre-certification (Refer to your insurance card or call KePRO 7 days prior to date of service).

Looking for a Health Care Provider

You may not know that your health insurance plan contains 3-tiers of provider networks of doctors, hospitals, and other facilities. In this 3-tier plan you will pay different levels of copayments, coinsurance, and/or deductibles depending on the tier of the provider delivering a covered service or supply.

Tier 1 - In-Network Providers: Doctors, hospitals, and other facilities that are located in Volusia, Flagler, Lake, Seminole and Orange Counties, that when utilized, will cost you the least.

Tier 2 - Expanded-Network Providers: Doctors, hospitals, and other facilities that are nationwide, outside of those listed in the above In-Network tier, that when utilized, will cost you more than the In-Network Providers.

Tier 3 - Out-of-Network Providers: Doctors, hospitals, and other facilities that are not listed in either of the above networks and when utilized, will cost you even more than the In-Network and Expanded-Network Providers.

Side by Side Example:

Non-Routine Personal Care Physician's Office Visit – ***The examples below are based on a total visit cost of $3,000****.* (Family Practice, General Practice, Pediatrics, OB/GYN,and Internal Medicine)

Tier 1	***Tier 2***	***Tier 3***
In-Network Provider	*Expanded-Network Provider*	*Out-of-Network Provider*
$0 Deductible*	**$500 Deductible*** ($3,000 – $500 = $2,500)	**$2,000 Deductible*** ($3,000 – $2,000 = $1,000)
$25 Co-Pay	**$500 (20% Co-Insurance)** ($2,500/20% = $500)	**$400 (40% Co-Insurance)** ($1,000/40% = $400)
Cost to you: Only $25	**$1,000** ($500+$500=$1,000)	**$2,400** ($2,000+$400=$2,400)

Individual Calendar Year Deductible *(Employee only Coverage)*

Please refer Schedule of Benefits, page 1, 2 and 3, for other deductibles, co-pays, and/or co-insurances for each provider network.

To find doctors, hospitals, or other facilities (e.g. urgent care) access the following directories.

Tier 1 In-Network Providers

Tier 1 In-Network Providers are separated by counties. If you are looking for a particular doctor, hospital, or other facility, you would need to search each network.

Volusia and Flagler Counties

Florida Memorial Health Network
Website***:*** http://fmhn.org/search.php
*Customer Service: (*386) 231-4398 or (888) 839-7430

Volusia Health Network
Website: https://www.myvhn.com/provider-search-pdf.html
Customer Service: (386) 425-4846, Option 3 for Provider Relations Department

Lake, Orange, Osceola, and Seminole Counties

Florida Memorial Health Network - Expanded Network (FHHS)
Website: http://fmhn.org/search.php
Customer Service: *(*386) 231-4398 or (888) 839-7430

There are No Chiropractors in the ***Volusia, Flagler, Lake, Orange, Osceola, and Seminole*** county directory. Contact the Chiropractic Network – DPSC.

Chiropractic Network – DPSC
No website, employees must call Customer Service: (386) 615-0801

Tier 2 Expanded-Network Providers

Tier 2 Expanded-Network Providers are used if you are looking for a particular doctor, hospital, or other facility outside of the Tier 1 In-Network.

Multiplan
Website: http://multiplan.com/search/search-2.cfm?originator=84453
Customer Service: (888) 342-7427

HealthSmart HPO
Website: http://providerlookup.healthsmart.com/SearchProviders.aspx
Customer Service: (866) 511-4757

Tier 3 Out-of-Network Providers

Tier 3 Out-of-Network Providers are used if you are looking for a particular doctor, hospital, or other facility outside of the Tier 1 In-Network counties and Tier 2 Expanded-Network.

Other information available to you!

Both Volusia County's **Medical Coverage Program** (*HealthSmart*) and **Prescription Drug Coverage Program** (*Catamaran Rx*) provide a website that allows employees to access the following information:

To log into these websites, employees must enter a User Name/ID and Password. If a first time user, employees can also register on these websites.

Please call the Customer Service number if you have questions or problems with a website.

Medical Coverage Program: *HealthSmart* (Group Number 2081)
Website: https://daytona.healthsmart.com/pages/login.aspx
Customer Service: (855) 224-5173

- Medical Claim Information
- Request HPP ID Cards
- Medical Forms and Plan Documents
- Provider Directories (physicians, hospitals and other health care facilities)

Prescription Drug Coverage Program: *Catamaran Rx* (Group Number 612081)
Website: https://www.mycatamaranrx.com/PortalCentral/index.jsp
Customer Service: (800) 207-2568

- Pharmacy Locator
- Prescription Drug (Rx) Lookup
- Rx History
- Rx Mail Orders
- Rx Forms and Plan Documents

HEALTH PARTNERSHIP PLAN MISSION STATEMENT

Establish a partnership among plan employees, employers and medical providers that will promote quality cost-effective health care, informed decisions and healthful life styles.

INTRODUCTION

Benefits described in this booklet are effective January 1, 2016. This Plan is an amendment of the HPP originally effective April 1, 1986. In accordance with all applicable provisions of the Summary Plan Description of the County of Volusia Health Partnership Plan, the Health Partnership Plan has been amended as of 12:01 a.m., January 1, 2016, to provide benefits for expenses incurred on and after January 1, 2016, and other Plan provisions as set forth in this Summary Plan Description. Covered expenses incurred prior to January 1, 2016, will be administered in accordance with the terms of the Health Partnership Plan in effect through midnight, December 31, 2015. Your Group Number is 2081.

This manual has been prepared by the County of Volusia to assist you and other members of your insured group in understanding your Health Partnership Plan *(hereinafter referred to as HPP)*. It describes all the information you need to know about your health coverage, using a simplified format. It is divided into sections including enrollment, claims filing, benefit coverage, benefit limitations, definitions, and governmental protections. Some of the words used in this booklet begin with a capital letter. These words are defined in the Definitions section. When reading this booklet, it may be helpful to refer to this section.

All the benefits of your Health Plan are fully explained in this manual. These benefits include Medical, Pharmaceutical, and Behavioral Health services. It should be noted that all claims are to be directly filed with HealthSmart Benefits Solutions (HealthSmart). Pharmaceutical services and claims are handled by Catamaran Rx.

If you receive any information on this Plan and it is contradictory or silent in describing this Plan, this Summary Plan Description will prevail and is the governing document for this Plan.

To keep your medical costs to a minimum, all Hospital admissions and other specified surgical and medical services are to be precertified by KePRO by calling (888) 522-7742. Also, all Inpatient Behavioral Health Services are to be precertified by KePRO by calling (888) 522-7742.

This Plan shall not be construed as a contract, consideration, or inducement of employment, or as affecting in any manner or to any extent whatsoever the rights or obligations of the Employer or any Employee to continue or terminate employment at any time.

Section headings, sub-headings, heading size or typeface are used for convenience of reference only and will not affect the validity, construction or effect of the HPP provisions, and are not meant to convey or imply that any greater or lesser benefits are covered under the HPP.

THIS PLAN MAY CONTAIN CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES, AND PENALTY PROVISIONS.

PLEASE READ THIS DOCUMENT CAREFULLY.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

INDIVIDUAL MAXIMUM LIFETIME BENEFIT **NONE**

FERTILITY STUDIES - MAXIMUM CALENDAR YEAR BENEFIT **$2,000**

Expenses incurred by a Non-Network provider will be paid in accordance with the Expanded Network benefits if incurred on a Medical Emergency/Life-Threatening basis. Reasonable and Customary will not apply and the Calendar Year Deductible will be waived. Refer to page 29, under ER Room, Urgent Care.

If an In-Network facility is utilized, any ancillary charges incurred by an Expanded-Network or Out-of-Network provider will be paid as In-Network. Reasonable and Customary will not apply.

If an Expanded-Network facility is utilized, any ancillary charges incurred by an Expanded-Network or Out-of-Network provider will be paid in accordance with the Expanded-Network benefits

If an In-Network provider is utilized, any ancillary charges incurred by an Expanded-Network or Out-of-Network provider or facility will be paid in accordance with their respective schedule of benefits. The ancillary charges will not be paid at the In-Network level of benefits. (For example, if a member went to a network doctor and the doctor used a non-network facility to do surgery, the doctor would be paid as network and the facility would be paid as out-of-network. They would not both be paid as network.)

	In Network	Expanded Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE			
Individual	$250	$500	$2,000
Family	$750	$1,500	$6,000
OUT-OF-POCKET MAXIMUM EXPENSE - INCLUDES CO-PAYS & CO-INSURANCE PERCENTAGES (Includes Medical, Pharmacy and Behavioral Health Expenses)			
Individual Per Calendar Year	$5,000	$5,000	$10,000
Family Per Calendar Year	$10,000	$10,000	$20,000
PREVENTIVE CARE BENEFIT			
Annual Physical Exam	$0	$0	40%
Well Woman Services	$0	$0	40%
Well Child Care Services	$0	$0	40%
PHYSICIAN SERVICES			
Personal Care Physician's Office Visit (Family Practice, General Practice, Pediatrics, OB/GYN & Internal Medicine)	$25	20%	40%
Specialist's Office Visit	$40	20%	40%
Obstetrical Care Including Delivery (One-time charge)	$105	20%	40%
Physician Inpatient Visit	$0	20%	40%
Physician Inpatient Surgical Services	$0	20%	40%
Outpatient Surgery	$40	20%	40%
Office Surgery - (includes, but is not limited to, joint injections, fetal stress tests, nasal endoscopies)	$40	20%	40%
Allergy Injections	$0	$0	$0

SCHEDULE OF BENEFITS

	In Network	Expanded Network	Out-of-Network
Immunizations/Inoculations (Not part of Annual Physical Exam Benefit; however, when obtained from Volusia County Health Department, will be paid as In-Network	$30	20%	40%
WALK-IN CLINIC (Non-Emergency - Refer to Provider Directory)			
Personal Care Physician (PCP)	$25	20%	40%
Specialist	$40	20%	40%
URGENT CARE/WALK-IN FACILITY/CLINIC (Emergency – Refer to Provider Directory)			
Emergency Services - per visit -	$50	20%	40%
		Deductible will not apply	
HOSPITAL SERVICES			
Inpatient Services - Per Admission (per day 3 day max.)	$250	20%	40%
Outpatient Surgery - Per Surgery (includes 23-hour observation) Per day, 3 day max.	$250	20%	40%
EMERGENCY SERVICES - PER VISIT			
Emergency Room (waived if admitted)	$65	$65	$65
		Deductible will not apply	
Ambulance Services (Volusia County EVAC Services will be paid as In-Network)	$65	20%	40%
DENTAL (see page 35 for covered services)			
(See Teeth, Gums and Alveolar Process)			
Office Surgery	$35	$35**	$35**
Office Visit	$35	$35**	$35**
Impacted Teeth Surgery	$35	$35**	$35**
		****Subject to Usual & Customary Charges**	
SKILLED NURSING FACILITY - PER ADMISSION	$55	20%	40%
HOSPICE	$0	20%	40%
OUTPATIENT LAB, X-RAY & OTHER DIAGNOSTIC PROCEDURES - PER VISIT			
Diagnostic X-Rays	$25	20%	40%
CAT	10%*	20%	40%
MRI	10%*	20%	40%
Lab Tests and Services	$25	20%	40%
Sleep Study	$25	20%	40%
		***Deductible Applies**	
CHEMOTHERAPY/RADIATION THERAPY	$0	20%	40%
DIALYSIS	$0	20%	40%

SCHEDULE OF BENEFITS

	In Network	Expanded Network	Out-of-Network
OUTPATIENT THERAPIES - PER VISIT (Chiropractic, Massage, Occupational, Physical, Speech, and ABA Therapy)	$25	20%	40%
HOME HEALTH (see page 62 for definition)	$0	20%	40%
DURABLE MEDICAL EQUIPMENT/ORTHOPEDIC DEVICES (Per Item) (does not include diabetic supplies, see page 28 for definition)	$25	20%	40%
MEDICAL SUPPLIES (for medical supplies other than diabetic supplies or DME, see page 30 for definition)	$15	20%	40%
Breast Prostheses	$10	20%	40%
Wigs (Deductible does not apply)	$10	$10	$10
PROSTHETIC DEVICES - PER DEVICE	$105	20%	40%
NUTRITIONAL COUNSELING FOR DIABETES (Refer to Disease Management information in the Provider Director)	$0	20%	40%
CARDIAC REHABILITATION - OUTPATIENT	$0	20%	40%
BEHAVIORAL HEALTH BENEFITS			
Inpatient Services - Per Admission (per day 3 day max)	$250	20%	40%
Outpatient	$25	20%	40%
Rx	**Retail**	**Mail**	
Generic Tier 1	$20	$40	50%
Preferred Brand Tier 2	$35	$70	50%
Non-Preferred Brand Tier 3	$55	$110	50%

PRE-CERTIFICATION AND AUTHORIZATION OF MEDICAL CARE

KePRO provides utilization management of medical care for the Health Partnership Plan. Utilization management includes pre-certification of selected medical services to establish medical necessity and the appropriate level of care.

Pre-certification of the medical services listed below is mandatory, whether this Plan is providing primary or secondary coverage. It is the Employee's or Covered Person's responsibility to make certain that the compliance procedures of this program are completed. Failure to pre-certify before services are rendered will result in the following penalties (not to exceed Covered Charges):

Inpatient - $1,000 per admission
Outpatient - $250 per occurrence

The medical services listed below must be pre-certified by calling:
KePRO
(888)- 522-7742

--- All Inpatient Medical and Behavioral Care; and

--- The Following Surgical and Medical Services (performed in an outpatient setting):

- Adenoidectomy
- Applied Behavior Analysis (ABA) for Autism
- Back Surgery
- Chemotherapy
- Radiation
- Dialysis
- Colonoscopy – under age 50
- Durable Medical Equipment – **over $250** (Per Item – Per Treatment Plan)
- Endocrinology Services pertaining to Infertility/Reproduction
- Genetic Testing
- Home Health Care
- Hyperbaric Oxygen Treatments
- Hysterectomy
- Video Endoscopy
- Interventional Pain Services
- Mammaplasty; Reduction
- Massage Therapy
- Maternal & Fetal Medicine Specialty Services
- Nasal Surgery
- Occupational Therapy
- PET Scans
- Physical Therapy (Must request precertification as of day 1 - no penalty until visit 13)
- Septoplasty
- Sleep Apnea Studies
- Speech Therapy
- TMJ/CMJ Surgery
- Tonsillectomy
- Transplants - Tissue and Organ
- Varicose Vein Excision and Ligation

PRE-CERTIFICATION AND AUTHORIZATION OF MEDICAL CARE (Continued)

Scheduled Inpatient care should be pre-certified 7 days prior to admission. Emergency Inpatient admissions must be reported to KePRO within 24-hours or the next Working Day after an emergency admission.

Outpatient surgeries or other medical services should be pre-certified 7 days prior to delivery of medical services, or as soon as possible.

MEDICAL CASE MANAGEMENT - The primary objective of Medical Case Management is to identify and coordinate cost-effective medical care alternatives to help manage the care of patients who have catastrophic or extended care Illnesses or Injuries.

Medical Case Management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients, and others. Prior to any final determination, severity of condition and prognosis are taken into consideration.

KePRO assesses the need for alternative care and, when necessary, will refer the case for Medical Case Management.

KePRO provides a 24-hour Nurse Help Line at (877)-582-7061.

The **Utilization Management Program** also includes services for the management of large or potentially large claims. On a case-by-case basis as selected by the HPP Administrator (County of Volusia, Personnel Division), the Utilization Management Organization will provide an initial assessment of the patient, summarize the patient's continuing medical needs, assess the quality of current treatments, coordinate alternative care when appropriate and approved by the Physician and Plan Administrator, review the progress of alternative treatment after implementation, and make appropriate recommendations to the HPP Administrator.

In conjunction with these services, the HPP Administrator reserves the right to monitor health care and modify Plan benefits to assure that high-quality medical care is provided in the most cost-effective settings.

SPECIAL NOTICES

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee must contact the review organization to make certain that the Hospital or attending Physician has initiated the necessary processes.

HPP has the absolute authority to waive the normal provisions of this plan if KePRO submits a written proposed alternative which meets the accepted standards of medical practice without sacrifice of quality of patient care and is no more expensive than regular plan benefits would be.

All Precertification and Utilization Review requirements of the HPP will not apply to Surgical and treatment procedures associated with mastectomies of the Covered Employee or Covered Dependent as required pursuant to the Women's Health and Cancer Rights Act of 1998. Nor shall they apply to Hospital admissions of expectant mothers and newborns that are for periods no longer than 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section delivery as required by the Newborns' and Mothers' Health Protection Act of 1996, however, recommended stays longer than these periods will require you to follow the Precertification and Utilization Review Program of the HPP.

THIS PAGE CONTAINS PENALTY PROVISIONS.

PRE-CERTIFICATION AND AUTHORIZATION OF BEHAVIORAL HEALTH BENEFITS

Inpatient behavioral health care must be pre-certified and authorized for both medical necessity and appropriate level of care before accessing your behavioral health services and benefits.

Contact KePRO at (888) 522-7742 for pre-certification for you and your Counselor to discuss a treatment plan *before any services are rendered*.

Pre-certification of Inpatient Behavioral Health Services is *Mandatory*. It is an Employee's or Covered person's responsibility to make certain that the compliance procedures of this program are completed. Failure to pre-certify, before treatment or services rendered, will result in the following penalties (not to exceed Covered Charges):

Inpatient - $1,000 per admission

HPP has the absolute authority to waive the normal provisions of this plan if KePRO submits a written proposed alternative which meets the accepted standards of medical practice without sacrifice to quality of patient care and is no more expensive than regular Plan benefits would be.

For any Mental Health/Behavioral Health benefit or claim questions you will need to contact:

HealthSmart – (855) 224-5173

And, for any Mental Health/Behavioral Health Provider listings or questions contact:

Florida Memorial Health Network (386) 231-4398/(888) 839-7430; or

Volusia Health Network (386) 425-4VHN (4846).

THIS PAGE CONTAINS PENALTY PROVISIONS.

PREVENTIVE SERVICES

This Plan may cover Annual Physical Examinations for Covered Employees and Covered Spouses and Covered Dependent Children. Well Woman Services are provided for Covered Employees, Covered Spouses and Covered Dependent Children.

Preventive Care

Preventive and Wellness Services for Adults and Children – In compliance with section (2713) of the Affordable Care Act, benefits are available for evidence- based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

With respect to infants, children and adolescents, evidence-informed Preventive Care and screenings as provided for in the compliance guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive and Wellness Services can be found at: https://www.healthcare.gov/preventive-care-benefits/.

Women's Preventive Services- With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

- Well woman visits
- Gestational diabetes screenings
- HPV DNA testing
- Sexually transmitted infection counseling
- HIV screening and counseling
- FDA approved contraception methods and contraceptive counseling
- Breastfeeding support, supplies and counseling
- Domestic violence screening and counseling

A description of Women's Preventive Services can be found at http://www/hrsa.gov/womensguidelines/ or at https://www.healthcare.gov/preventive-care-benefits/.

Well Child Care Services

The HPP covers certain Well Child Services provided by a Physician from the moment of birth through the end of the year in which they turn 19.

The Covered Services for each visit to the Physician include:

- Physical exam and measurements
- Vision and hearing screenings
- Oral health risk assessments
- Developmental assessments to identify any developmental problems
- Screenings for hemoglobin level, lead, tuberculin
- Counseling and guidance from your doctor about your child's health development
- Appropriate immunizations and boosters, including HPV immunizations
- Laboratory tests

PREVENTIVE CARE BENEFIT

To receive the maximum benefit, follow the steps below:

1. Select a Personal Care Physician from the Preferred Provider Directory under Family Practice, Pediatrician, General Practice, Gynecology, or Internal Medicine.

2. Call for an appointment:

   a. Identify yourself as a member of the Health Partnership Plan; and

   b. Tell them the appointment is for an annual physical covered by the HPP under the preventive care benefit.

3. Arrive early for appointment.

4. Present HPP membership card to office receptionist.

5. Present list of covered examination and screenings to Physician. See page 7.

6. Verify that the Physician's office codes the claim as preventive care and forwards the claim to HealthSmart No Deductible or Co-Payment is applied.

7. All additional laboratory tests and screenings should be done at participating labs or Hospitals. (Check Provider Directory.)

8. Present HPP membership card at lab and verify that the coding is preventive care benefit. Send claim to HealthSmart for processing. No Deductible or Co-Payment is applied.

9. Well woman screenings are covered at 100%.

10. If the Physician finds a health problem that requires additional office visits, additional tests for diagnostic purposes, or treatment, these charges may be applied to your Deductible. These charges may be subject to Precertification and appropriate Co-Payment if applicable.

KePRO 24 Hour Nurse Line Information

Did you know the nation average ER wait time is 3 hours?
The benefits of using the nurse line will save you both time and money!

You now have access to trained Registered Nurses who will assist you in choosing the most appropriate care. They will take every opportunity to educate you on how to care for yourself now and in the future. The nurses are available via a toll-free number 24 hours a day, 365 days a year.

You may reach the Nurse Line at 877-582-7061.

The 24 hour nurse line en Espanola offers the only fully integrated Spanish language health information, advice and services.

The nurse line has an extensive library of topics. The Audio Library contains information on 2,200 topics – everything from Cancer and Heart Disease to Parent and Adolescent Concerns to Nutrition Tips. A list of library topics is available at www.fonemed.com/hiltopics.htm.

SCHEDULE OF PHARMACEUTICAL BENEFITS

	GENERIC DRUG	PREFERRED BRAND DRUG	NON-PREFERRED BRAND DRUG
	YOU PAY	YOU PAY	YOU PAY
CALENDAR YEAR DEDUCTIBLE PAYABLE BY COVERED MEMBER:	-0-	-0-	-0-
CO-PAYMENT PAYABLE BY COVERED MEMBER: Drugs purchased from a Catamaran Rx network retail Pharmacy			
Each 30-day supply	$20	$35	$55
CO-PAYMENT PAYABLE BY COVERED MEMBER: Drugs purchased from Catamaran Rx Mail Service Pharmacy			
31- to 90 day supply	$40	$70	$110
CO-INSURANCE PERCENTAGE PAYABLE: Drugs purchased from a non-network Pharmacy			
Maximum 31-day supply	50%	50%	50%

Medications required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.

RETAIL 90
(Select Retail Pharmacies)
90-day Supply

Through the Retail 90 program, you can now get 90-day supply of your maintenance medications at select retail pharmacies.

Co-payment per prescription:

Non-Preferred name drug	$110
Preferred name drug	$70
Generic	$40

CATAMARAN RX PRESCRIPTION DRUG PROGRAM

Catamaran Rx provides the Pharmacy network for the Health Partnership Plan (HPP). Catamaran Rx has a nationwide network with more than 62,000 chain and independent pharmacies in the United States as well as a Mail Service Program for maintenance medications. For a list of Catamaran Rx pharmacies in Volusia County and Catamaran Rx chain pharmacies throughout the United States, please refer to the Health Partnership Plan Preferred Provider Directory or access their website at https://www.mycatamaranrx.com/PortalCentral/index.jsp.

Because Catamaran Rx pharmacies transmit claim information electronically, you must show your HPP ID Card for eligibility determination when filling a Prescription.

Maintenance drugs should be purchased through Catamaran Rx Mail Service or through the Retail 90program. Maintenance drugs are covered for up to a 90-day supply.

CATAMARAN RX PRESCRIPTION DRUG PROGRAM (Continued)

Mail Order Forms are included in your Catamaran Rx enrollment packet or via the website https://www.mycatamaranrx.com/PortalCentral/index.jsp.

To utilize your mail order benefit, please use the order form provided in your enrollment packet, calling the Catamaran Rx Customer Care Center listed on the back of your ID card, or, access forms on the web-site: https://www.mycatamaranrx.com/PortalCentral/index.jsp or mail to the following address:

Catamaran Home Delivery
PO Box 166
Avon Lake, OH 44012-9927

To access your personal prescription benefit information online go to https://www.mycatamaranrx.com/PortalCentral/index.jsp

By registering with the website you can conveniently:

- look up medications and verify your coverage and copayments;
- verify if a drug is included in our formulary (preferred medication list);
- compare copayments between generic and brand-name drugs;
- access your prescription history;
- get drug information; and
- verify eligible family members.

Under emergency circumstances with approval, prescription drugs may be obtained from a non-network Pharmacy. You will be reimbursed by the HPP for 50% of the cost of the Prescription whether the drug was generic or brand. A maximum 31-day supply applies to non-network Pharmacy purchases. Claims must be submitted to Catamaran Rx on a Member Prescription Claim Reimbursement Form available from your Benefits Office or accessing the form at the web-site https://www.mycatamaranrx.com/PortalCentral/index.jsp.

If you have questions about your Prescription drug benefit, Catamaran Rx Mail Service Program, the retail Pharmacy network, or about medications, please call the Catamaran Rx Customer Care Center at 800-207-2568. Catamaran Rx Pharmacists are well informed about Prescription drugs and will address your questions and concerns. If you need a replacement ID Card, please call HealthSmart at (855) 224-5173.

Automatic Generic Substitution

This plan automatically substitutes a generic drug for a brand drug when an approved generic drug is available. If you request a brand drug, or the prescribing Physician writes “Dispense As Written” because it is Medically Necessary to have the brand drug instead of the generic, the brand drug will be dispensed; however, you will be responsible for the non-preferred co-payment plus the cost difference between the brand and the generic drug.

For example if the brand name drug costs $100 and the generic costs $75, you will be responsible for the $55 non-preferred co-payment plus the $25 difference between the cost of the brand and cost of the generic drugs. Your cost will be $80.

If the cost of the brand name drug is $100 and the cost of the generic is $25, the difference would be $75 plus the non-preferred co-payment of $55 totaling $130. This is more than the cost of the non-preferred medication. In this example, you would only then pay the cost of the non-preferred medication which is $100.

If no approved generic substitute is available, the HPP will dispense and cover the brand drug.

CATAMARAN RX PRESCRIPTION DRUG PROGRAM (Continued)

Covered Medications
Medications covered by This Plan include all generic and brand drugs prescribed by a Physician unless excluded. Compound medications are covered if at least one ingredient is a legend drug. Diabetic supplies, including insulin, syringes, needles, chemical strips and glucose monitors are covered when prescribed by a Physician.

Dispensing Limitations
This Plan covers the amount prescribed by a Physician, but not to exceed a 30-day supply for drugs purchased from the retail Pharmacy or a 90-day supply for drugs purchased from the Catamaran Rx Mail Service Pharmacy.

ELIGIBILITY

Eligible Participants

All persons in a regularly established position with the County of Volusia classified as full-time or permanent part-time, who are scheduled to work 17-1/2 or more hours per week or on an approved Leave of Absence are eligible to be covered under this Plan after 31-days of employment.

All persons in a non-regularly established position with the County Of Volusia who has been identified to have worked an average of 30 hours or more per week during an initial or applicable standard twelve month measurement period.

A properly qualified COBRA Beneficiary is also eligible for Coverage in accordance with COBRA continuation provisions.

All eligible Employees who retire while covered by This Plan, and are eligible to receive benefits from the Florida State Retirement System, are eligible for Coverage.

Contracted employees and elected officials as approved by the HPP Administrator are also eligible for Coverage.

An Employee or Dependent cannot be covered if he/she is maintaining a residence outside the Continental U.S.

An Employee cannot be covered as both an Employee and as a Dependent under this Plan.

Eligible Dependents

Your Eligible Dependents, as defined below are eligible for Coverage under this Plan. A newborn child of a covered Dependent child is eligible to participate from birth up to age 18-months.

Dependent means the Covered Employee's spouse and children.

The term "***spouse***" means the legally recognized marital partner, as defined by Florida law, excluding the domestic partner, of a Covered Employee. The term shall exclude such spouse who has divorced the Employee, or who is legally separated from the Employee.

The term "***children***" means natural children, step-children, foster children, or children who have been placed under legal guardianship and legally adopted children from birth to age 26 (whether married or unmarried). This applies to any children regardless of marital status, full-time student status, level of support from employee/parent, or residence.

The term "***children***" also means pre-adopted children (i.e., children placed with a Covered Employee in anticipation of adoption.) Such children will be provided Coverage under the same terms and conditions that apply to Dependents who are a Covered Employee's natural children, irrespective of whether the adoption has become final, and is enrolled in a timely manner as stated within.

The term "***children***" also means a Covered Member's child who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to Coverage under This Plan as an "alternate recipient." The HPP Administrator will communicate the procedures which have been established to determine whether a Medical Child Support Order is qualified under ERISA Sec. 609, and within a reasonable time after receiving an order will determine whether or not the order is qualified, and whether or not the child has been determined to be an "alternate recipient." The Covered Employee and each child who is the subject of the order will be notified of the determination. Such children may designate a representative to receive copies of all such notices.

ELIGIBILITY (Continued)

A child determined to be an **"alternate recipient"** will be provided Coverage under the same terms and conditions that apply to Dependents who are a Covered Employee's natural children and is enrolled in a timely manner as stated within.

All children are eligible for Coverage until the end of the year in which the child reaches the age of 26. However a child may be deemed a Dependent until the end of the calendar year in which the child reaches the age of 30, so long as the child meets the following conditions:

- Must either live in Florida or be a full-time or part-time student whose parent resides in Florida;
- Must not be married;
- Must not have a dependent of his or her own;
- Must not be covered by another health plan or policy (group or individual) or by Medicare; and
- If the child was covered under the parent's health insurance policy up to the age 26 and that coverage was subsequently terminated, the child must have been continuously covered by other health insurance without a gap in coverage of more than 63 days in order to re-enroll in the parent's health insurance policy.

Dependent children from age 26 to 30 will incur additional cost for the coverage; see your Benefits Department for details.

If the employee fails to notify the HPP Administrator, in writing within 60 days, of a Dependent's change in eligibility status, the Dependent shall lose the right of Continuation of Coverage under COBRA. (See the COBRA section of this book for further details.)

Special Exception for Medical Necessity (Michelle's Law): Notwithstanding the foregoing a covered Employee's unmarried child will not immediately lose eligibility to participate in the Plan if such child loses his or her required student status as a result of a change in enrollment (included a leave of absence) that (i) is medically necessary and (ii) commences while the child is suffering from a serious illness or injury. This special exception for medical necessity will delay termination of coverage until the earlier of one year from the first day of the medically necessary leave of absence or the date that the Dependent would otherwise lose coverage under the Plan for reasons other than student status (e.g. age limitations), unless the child regains full-time student status prior to such termination date.

The term ***Dependent*** also includes an Employee's unmarried child while the child is Physically, or Mentally Handicapped and is incapable of earning his own living, and who is actually dependent on either parent for a majority of his maintenance and support, and who is a Covered Member on the date immediately preceding the date his health Coverage would have terminated due to age. Proof of incapacity must be submitted to the HPP Administrator within 31-days of the date his health Coverage would have terminated due to age.

In the event both parents of an eligible Dependent child are Covered Members, then for the purposes of this Coverage, such child is considered as a Dependent of either parent, but not both parents.

No eligible person can be a Covered Employee and a Covered Dependent at the same time. No person can be covered as a Dependent of more than one Employee.

ELIGIBILITY (Continued)

Your Eligible Dependents are eligible for Coverage on the date you become eligible for Coverage or on the date you first acquire a Dependent. There are, however, special rules that apply to newborn children and adopted children. Refer to those specific provisions for further information.

A properly qualified COBRA Beneficiary is also eligible for Coverage in accordance with COBRA continuation provisions.

No person may participate in this Plan as a Dependent of more than one Employee.

Requirements

Coverage will not become effective unless a properly completed and signed enrollment application is submitted. No Coverage will be placed in effect unless the required payroll deductions, if any, are paid to the HPP. As explained under "IRS SECTION 125 - FLEXIBLE BENEFIT PLANS," your employer will deduct your contributions before taxes are calculated and deducted from your paycheck.

You must enroll within the first 14-days of your employment date. If you desire Dependent Coverage, you must also enroll your eligible Dependents at that time. Dependents you acquire after this time must be enrolled within 31-days of the date you acquire them.

As a requirement for enrollment in the Plan, all Eligible Dependents of Covered Employees will be required to provide their social security number to the Plan Administrator. This is necessary to allow the Plan Administrator to comply with any and all reporting requirements imposed under federal CMS guidelines.

Genetic Information Nondiscrimination Act ("Gina").

"**GINA**" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

"Family members" include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption.

"Underwriting" includes any rules for determining eligibility, computing premiums or contributions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care provider who is treating an individual from requesting that the patient undergo genetic testing.

ELIGIBILITY (Continued)

The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

IRS SECTION 125 - FLEXIBLE BENEFIT PLANS

Federal tax law, Section 125 of the Internal Revenue Code, authorizes the establishment of Flexible Benefit Plans, sometimes called FlexPlans. These FlexPlans are set up by employers to assist their Employees in saving money by allowing Employees to pay for certain expenses with pre-tax dollars. This means they are not subject to withholding for federal income tax, social security tax and the income tax of most states.

The Pre-Tax Premium Plan allows Employees to pay for their group health benefit coverage with pre-tax dollars by authorizing their employers to take payroll deductions for the cost of the coverage before taxes are calculated and deducted from the Employee's paycheck.

Participation in the FlexPlan lowers taxes by reducing the amount of taxable income. How much taxes are lowered depends on many things: total taxable income, whether or not an individual or joint return is filed, federal and state tax rates, whether or not deductions are itemized or the standard deduction is taken, the number of exemptions and so forth.

Social Security benefits may be affected for those whose earnings are below the Social Security Taxable Wage Base. Otherwise, there should be no unfavorable consequences to participating in a Flexible Benefit Plan.

Section 125 of the Internal Revenue Code which allows these special tax breaks also imposes the strict requirement that the choices an Employee makes must stay in effect for a full plan year, or through the end of the plan year in which the Employee becomes a participant.

Employees cannot add, drop, or change coverage except during the Annual Choice Period or within 31-days of a Change in Status as described below.

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The County of Volusia has established a Pre-Tax Premium Plan and your premium expenses (for yourself and all enrolled eligible Dependents) for medical will be paid with pre-tax dollars.

You are not required to participate in the County of Volusia Health Partnership Plan, but if you do enroll for coverage, participation in the Pre-Tax Premium Plan is mandatory and automatic. Your premium expenses will be deducted from your paycheck before any taxes are calculated and deducted.

If you do not want to participate in the Pre-Tax Premium Plan you must sign a Refusal of Coverage, declining any coverage offered under the HPP and provide proof of other health insurance coverage.

Once you elect to participate in the Pre-Tax Premium Plan, you cannot add, drop or change your coverage until the next Annual Choice Period, which will be the month of November each year, unless there is a Change in Status as described below. In the case of a Change in Status, you have 31-days from the date of the event to make any changes.

IRS SECTION 125 - FLEXIBLE BENEFIT PLANS (Continued)

Make your decision carefully. You will not be able to change your coverage, or stop your contributions during the year unless one of the following changes in status occurs:

1. The marriage, divorce, or legal separation (where legally recognized) of an Employee;
2. The death of the Employee's Spouse, or a Dependent;
3. The birth, or adoption of a child of the Employee;
4. The termination, or commencement of employment of Employee's Spouse;
5. The switching from part-time to full-time employment status, or from full-time to part-time status by the Employee, or the Employee's Spouse;
6. The taking of an unpaid Leave of Absence by the Employee, or Employee's Spouse;
7. A significant change occurs in the health coverage of the Employee, or Spouse attributable to the Spouse's employment; or
8. The loss of coverage related to Medicaid or SCHIP (see page 20).

ENROLLMENT & ENROLLMENT DATES

All New Employees and Dependents Enrolled in a Timely Manner

An Employee may enroll in the HPP for Employee and Dependent coverage on, or before the 14th day following his employment date. Employee and Dependent Coverage begin on the first day of Employee's employment.

New Employees NOT Enrolled in a Timely Manner

If an Employee does not enroll in the HPP in a timely manner or refuses coverage at the time of enrollment, and does not provide proof of other health care coverage to the HPP Administrator, then the Employee will be automatically enrolled in single coverage by the HPP Administrator. (The premium for this coverage is paid for by the employer.)

Enrolling Newly Acquired Dependents

If an Employee does not have an Eligible Dependent when his Coverage first becomes effective and then later acquires an Eligible Dependent for the first time (other than through the birth, or adoption of a child), the Employee may apply for Dependent coverage within 31-days from the date the Eligible Dependent was first acquired. Coverage will begin on the first day of the pay period following the date the application for Coverage was made.

CHANGE IN STATUS

If, as a result of a change in status, an Employee has the right to add additional Coverage, then the Employee will have 31-days after the date of the event that constituted the change in status to notify the HPP of his or her new election. If an Employee fails to notify the HPP within this 31 day period, he would not be eligible to apply for the additional Coverage until the next Annual Enrollment Period.

If, as a result of a change in status, an Employee has the right to reduce Coverage (or if Coverage is automatically reduced under the group health care Plan), the Employee will have 31-days after the date of the Change in Status to notify the HPP of his election to reduce Coverage. If the Employee notifies the HPP within this 31 day period, the change of Coverage will apply the last day of the pay period in which your Status Change is approved, as defined in the Flexible Benefits Plan. (Please see the COBRA section of this book for information regarding the continuation of coverage for members that no longer have coverage.)

SPECIAL ENROLLMENT RULES

If you do not enroll in the HPP within the first 14-days of employment, you may not enroll in the HPP until the next Annual Enrollment Period. However, if you decline enrollment in the HPP for yourself, or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be eligible for "special enrollment", which would allow you to enroll yourself, or your Dependents in the HPP, but only if both:

1. At the time you decline Coverage, you give a written statement to HPP Administrator that the reason you, and/or your Dependents are declining enrollment is because of coverage under another group health plan, or other health coverage; and

2. You request enrollment within 31-days after the other coverage ends.

If you meet these requirements, your Coverage will be effective retroactive to the date the other coverage ends.

If you are not eligible for this special enrollment, and if you are not eligible to enroll because of a change in status, you may not enroll in the HPP until the next open enrollment period as described above.

To verify your eligibility for this special enrollment, the HPP Administrator may request and obtain information, such as the reasons your prior coverage terminated. Acceptable reasons are termination of an employer's contribution towards the other coverage or loss of eligibility for the other coverage, for example, due to legal separation, divorce, death, termination of employment, reduction in the number of hours worked, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Reasons that are not acceptable are failure to pay premiums on a timely basis or termination of other coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the HPP).

In addition, if you have a new Dependent or Dependents as a result of marriage and you are otherwise eligible for coverage under the HPP, you may enroll yourself and your new Dependent(s) provided that you request enrollment within 31-days after the marriage. If timely application is made, coverage will be effective retroactive to the date of the marriage.

SPECIAL ENROLLMENT RULES (Continued)

If you have a new Dependent as a result of birth, adoption, or placement for adoption, and you are otherwise eligible to be enrolled in the HPP, you may enroll your new Dependent, yourself, and your spouse, provided that you request enrollment within 31-days after the birth, adoption, or placement for adoption. If timely application is made, coverage will be effective as of the date of the birth, adoption, or placement for adoption.

Special Enrollment Related to Medicaid and SCHIP. You or your Dependent may be eligible for Special Enrollment in the HPP if you or your Dependent:

1. lose coverage under a Medicaid or a State Children's Health Insurance Program under titles XIX and XXI of the Social Security Act (referred to, respectively, as "Medicaid Plan" and "State Plan"); or

2. become eligible for group health plan premium assistance under a Medicaid Plan or State Plan; and

3. you request enrollment in the HPP within 60 days after the coverage under the Medicaid or State Plan ends you or your Dependent become eligible for Premium assistance under a Medicaid or State Plan.

If you meet these requirements, your Coverage will be effective on the first day of the following pay period once receipt of the fully completed enrollment form.

To verify your eligibility for this Special Enrollment, the HPP Administrator may request and obtain additional information.

NEWBORN CHILDREN

1. If you are a Covered Employee and you notify the Employer, in writing, of the birth of your newborn child within thirty-one (31) days after the date of birth, Coverage for the newborn becomes effective on the date of birth and any additional premium applicable to the newborn will be waived for the thirty-one (31) day notice period.

2. If notice is given after thirty-one (31) days from the date of birth, but within sixty (60) days from the date of birth of the newborn child, Coverage for the newborn becomes effective on the date of birth only if any additional premium applicable to the newborn, from the date of birth, has been paid.

3. If notice is not given within sixty (60) days from the date of birth of the newborn child, the Covered Employee may not enroll the newborn in the HPP until the next Annual Enrollment Period.

CHANGES IN COVERAGE

Changes in Coverage will be effective on the first day of the pay period in which the change occurred. Any changes involving increased Coverage will be subject to the applicable provisions of the Eligibility and Enrollment Dates requirements, and the rules and regulations regarding IRS Section 125 - Flexible Benefits Plans.

For retired Employees, any changes in Coverage based on attaining a stated age will be made in the calendar month in which such birthday occurs.

TERMINATION OF COVERAGE

Employee Termination

The Coverage of an Employee covered under this Plan shall terminate on the earliest of the date:

1. the last day of the pay period in which they terminate employment, or

2. the Group Plan Coverage terminates, or

3. the last day premiums are paid, or

4. the Employee is no longer considered to be an Employee eligible for Coverage, or

5. COBRA Continuation Coverage terminates, if the Employee had elected such Continuation Coverage.

6. Continuation Coverage as set forth in the Uniformed Services Employment and Reemployment Rights Act terminates, if the Employee, who was on duty in the Uniformed Services for more than 31-days, had elected such Continuation Coverage.

7. Plans may not rescind coverage once a member is covered unless the member's act, practice or omission constitutes fraud, or if the member intentionally misrepresented the facts as prohibited by the terms of the plan or coverage

Dependent Termination

The Coverage of any Dependent covered under This Plan shall terminate on the earliest of the date:

1. the Employee's Coverage terminates, or

2. the Group Plan Coverage terminates, or

3. the last day Dependent premiums are paid, or

4. a Dependent no longer qualifies as an eligible Dependent as defined by the HPP, or

5. the Dependent becomes a Full-Time member of the Armed Forces of any Country, or

6. COBRA Continuation Coverage terminates, if the Dependent had elected such Continuation Coverage.

7. Continuation Coverage as set forth in the Uniformed Services Employment and Reemployment Rights Act terminates, if the Dependent of an Employee, who was on duty in the Uniformed Services for more than 31-days, elected such Continuation Coverage.

LEAVES OF ABSENCE

Approved, Full or Partial, Paid Leave of Absence
Coverage paid by the County continues during the approved paid Leave of Absence. Dependent and Employee premiums continue to be deducted.

Family Medical Leave Act
Approved Leave of Absence for 12-weeks or less. Coverage paid by the County continues as if an active Employee. Dependent and Employee premiums are paid directly to Personnel Services.

Approved Unpaid Leave of Absence
Coverage paid by the County terminates, and Employee is eligible to elect COBRA Continuation of Coverage with the Employee paying premiums at the applicable rate.

Normal Retirement (Florida Retirement System)
Coverage may be continued indefinitely, subject to timely premium payments. To qualify, "normal retirement" is:

- Before July 1, 2011 - age 62 with six years of vested service or 30 years of service at any age (age 55 with six years of service or 25 years of service for Special Risk).

- After July 1, 2011 - age 65 with eight years of vested service or 33 years of service at any age. (age 60 with six years of service or 30 years of service for Special Risk).

Or

- Have reached the age of 59½ and have six (before July 1, 2011) or eight (after July 1, 2011) years of Florida Retirement System vested service.

Or

- Approved for Florida Retirement System disability retirement

Continuation Coverage will not become effective until the full and correct initial payment is made and received. Subsequent payments are due on the first day of each month of Coverage. Premiums are delinquent if not paid by the end of the month following the due date, in which event Continuation Coverage will cease, without notice, retroactive to the first day of the month for which payment has not been made. A check that is dishonored for any reason will not be considered payment.

Dependent coverage for the covered Dependent spouse of a Retiree will not terminate upon the death of the Retiree but shall continue indefinitely, subject to timely premium payments.

National Defense Authorization Act (NDAA)

Regardless of an Employer's established Leave of Absence policy, the HPP will at all times comply with the following regulations:

The **National Defense Authorization Act** (NDAA) which expands Family Medical Leave (FMLA) to include employees caring for an injured service member as well as family members who have a family member called to active duty. The Act permits a "spouse, son, daughter, parent, or next of kin" to take up to 26 workweeks of

leave to care for a “member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.” This Act also permits an employee to take FMLA leave for “any qualifying exigency (as the Secretary of Labor shall, by regulation, determine) arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.”

Additional information concerning the NDAA can be obtained from your Human Resources Department.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Regardless of the Employer's established Leave of Absence policies, This Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act for Covered Employees going into or returning from military service. These rights include up to 24-months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate Coverage in This Plan upon return from service.

Plan exclusions and waiting periods may be imposed for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

For additional information concerning the USERRA, including your rights and responsibilities under the Act, please contact Personnel Services.

GENERAL PLAN PROVISIONS

All benefits provided under This Plan are subject to the following basic terms and conditions. A thorough reading and understanding of these terms and conditions will help you maximize your Plan benefits.

Benefit Maximums
Total Plan payments for each Covered Member are limited to certain Benefit Maximums. A Benefit Maximum can apply to a specific benefit or to all benefits. A Benefit Maximum can be a specific dollar limit; a specific limit on services, such as number of visits or days; a specific time period or any other specific limit imposed upon a benefit, or benefits, by This Plan.

The Benefit Maximums that apply are shown in the individual Schedule of Benefits of This Plan.

Deductibles
A Deductible is the amount that must be paid toward Covered Expenses before This Plan will start reimbursement. Deductibles do not track toward Out-of-Pocket Maximum Expenses.

This Plan may contain separate Network and Out-of-Network Deductible amounts as outlined in the Schedule of Benefits. If both types of providers are used, the amount paid toward the Deductible(s) will track towards each other in satisfying the required Deductible(s). Therefore, the amount paid towards the Deductible(s) will not exceed the higher Deductible amount.

Individual Deductible
The individual Calendar Year Deductible amount is shown in the Schedule of Benefits.

Family Deductible
If Dependents are covered under This Plan, separate Deductibles apply until family members accumulate an equivalent amount of a total of three (3) Deductibles during a calendar year.

Carry-Over Deductible
The Deductible is applied each calendar year; however, Covered Expenses incurred during the last three (3) months of a calendar year (October, November, December) that are applied toward meeting that year's Deductible will be carried over and applied toward the satisfaction of the next year's Deductible.

Co-Pay/Co-Payment(s)
A Co-Pay or Co-Payment is the amount that must be paid toward Covered Expenses before the HPP will start reimbursement. The Co-Pay or Co-Payment(s) also track towards the Out-of-Pocket Maximum Expenses.

There will be an additional Co-Payment per occurrence for failure to follow Pre-certification Requirements. Refer to the provision entitled, “PRE-CERTIFICATION AND UTILIZATION REVIEW PROGRAM” for further information.

Co-Insurance Percentage
The Co-Insurance Percentage is the portion you will pay for eligible Covered Expenses, after the Covered Member satisfies any applicable Deductibles or penalties. The Co-Insurance Percentages also track towards the Out-of-Pocket Maximum Expenses.

For Covered Services received from a network Provider, Covered Expenses are limited to the negotiated fees of the Network. The Covered Member is not responsible for payment of charges exceeding the negotiated fees.

GENERAL PLAN PROVISIONS (Continued)

For medical services received outside the Network, Covered Expenses are limited to Usual and Customary, and Reasonable Charges. The Covered Member is responsible for any charges exceeding Usual and Customary, and Reasonable guidelines.

The Co-Insurance Percentages for Covered Expenses are shown in the Schedule of Benefits.

Lifetime
The word "Lifetime" means the period of time a Covered Member is a participant in This Plan, whether in one period of time or in separate periods of time.

Medical Necessity
This Plan may only provide benefits for Covered Services and supplies that are Medically Necessary for the treatment of a covered Illness, or Injury with the exception of Preventive Services.

Out-of-Pocket Maximum Expense
You are responsible for paying any covered expense at the Co-Insurance Percentage(s) shown in the Schedule of Benefits. The remaining portion of the charge is the HPP's Out-of-Pocket Expense.

The Maximum Out-of-Pocket Expense is the total amount that must be paid toward Covered Expenses during a calendar year before the Co-Insurance Percentage of This Plan automatically increases to 100%.

This Plan may contain separate Network and Out-of-Network Out-of-Pocket Maximum Expense amounts as outlined in the Schedule of Benefits. If both types of providers are used, each Out-of-Pocket Maximum Amount must apply.

The following items CANNOT be applied to the Out-of-Pocket Maximum amount: charges above the network negotiated fee schedule(s), charges over Reasonable and Customary Charges, any penalties for failure to pre-certify services and/or ineligible expenses.

❖ **Individual Out-of-Pocket Maximum Expense**
When a Covered Member has paid, as stated in the Schedule of Medical Benefits, the applicable out-of-pocket amount in a calendar year for Covered Medical and Behavioral Health Expenses incurred from the appropriate Provider, this Plan may pay all Covered Medical and Behavioral Health Expenses incurred from the appropriate Provider for the remainder of the calendar year.

❖ **Family Out-of-Pocket Maximum Expense**
When Covered family Members, as a unit, have paid as stated in the Schedule of Medical Benefits, the applicable out-of-pocket amount in a calendar year or individually up to the statutory limits for individuals for Covered Medical and Behavioral Health Expenses incurred from the appropriate Provider, this Plan may pay all Covered Medical and Behavioral Health Expenses incurred from the appropriate Provider for the remainder of the calendar year.

Replacement of Another Plan
If This Plan of benefits replaces an Employer's prior plan of group medical benefits, and if an Employee (a) becomes covered by This Plan on its effective date, and (b) has been covered by the Employer's prior plan of group medical benefits on the day before This Plan took effect, the HPP Administrator has full power and authority and absolute discretion to waive or give credit for any amounts applied to the prior plan's calendar year Deductible and out-of-pocket amount(s) of the prior plan toward satisfying the Deductible and out-of-pocket amount(s) of This Plan.

GENERAL PLAN PROVISIONS (Continued)

Usual and Customary, and Reasonable Charges

This Plan may only provide benefits for Covered Expenses that are equal to, or less than the Usual and Customary, and Reasonable Charge in the geographic area where services or supplies are provided. Any amounts that exceed the Usual and Customary, and Reasonable Charges are not covered by This Plan.

YOUR RIGHT TO DEMONSTRATE CREDITABLE COVERAGE

You are entitled to a certificate from your previous health care provider that will show evidence of your prior health coverage. A plan, or issuer is required to furnish a certificate automatically and without charge at the time the individual loses coverage under the plan, or would have lost coverage in the absence of COBRA or similar coverage. A plan, or issuer is also required to issue a certificate automatically to an individual who has elected COBRA coverage when that coverage ceases. You or your authorized representative may also request a certificate from a prior plan or issuer within 24-months after the coverage ceases. The HPP will assist in obtaining a certificate from any prior plan or issuer, if necessary. Please contact the Personnel Services Department if you need assistance.

COVERED MEDICAL EXPENSES

An expense is considered to be incurred on the date the Covered Member receives the services and supplies for which a charge is made.

Ambulance Charges
This Plan may cover the use of a local professional land or air ambulance service to transport a Covered Member to, but not returning from, the nearest Hospital appropriate for the Covered Member's condition. Trips from the home of the Covered Member or the scene of an Accident to a Hospital or to a Skilled Nursing Facility are also covered, if Medically Necessary. Service is local if the Covered Member is carried no more than 50 miles from the place of pickup to a covered facility.

Emergency transportation charges for a Covered Member for regularly scheduled commercial transportation by train or plane within the continental U.S. to the nearest Hospital that has medical treatment not available locally for special Inpatient treatment are covered when such treatment has been certified as necessary due to the emergency nature of an Accident or Illness.

Anesthesia Charges
Charges for Anesthetics and the administration of Anesthesia by a licensed Anesthesiologist or certified Registered Nurse Anesthetist in connection with a covered Surgical Procedure when these are not covered as Hospital Charges are covered by This Plan.

Birthing Centers
Charges made by a licensed Birthing Center for a covered childbirth and the associated normal services and supplies are covered by This Plan.

Room and Board Charges are not covered. Recuperation must take place outside the Birthing Center.

Chiropractic Services
This Plan covers a spinal manipulation with the diagnosis of subluxation for 12 visits per calendar year. After the initial 12 visits, a Treatment Plan must be approved by the HPP if the Covered Member is to receive Coverage for additional services. The Treatment Plan must be filed with DPSC for the HPP to establish Medical Necessity and appropriate level of care.

Chiropractic treatment to maintain current levels of functioning or to prevent deterioration is not covered.

Colonoscopy
Charges for routine screening and diagnostic colonoscopies for covered members 50 years of age and older will be covered under the outpatient surgery benefit. Routine colonoscopies for covered members under age 50 are not a covered benefit. Diagnostic colonoscopies for covered members under age 50 will be a covered benefit if precertification is obtained and if it is performed in conjunction with treatment of an active condition. This will be payable under the outpatient surgery benefit.

Convalescent/Skilled Nursing Facility
Charges incurred for confinement in a Convalescent or Skilled Nursing Facility may be covered by This Plan at the semi-private room rate, provided the confinement is due to the same or related causes that caused hospitalization. Successive confinements separated by less than three months for the same cause are not covered.

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 4 AND PAGE 6

COVERED MEDICAL EXPENSES (Continued)

Diabetic Supplies
This Plan covers diabetic supplies purchased through the Prescription Drug Program only. Said diabetic supplies are not covered if they are purchased from a Durable Medical Equipment vendor.

Diagnostic X-Ray and Laboratory Benefit
This Plan may cover expenses for x-ray treatments and examination, microscopic tests, or other lab tests or analyses made for diagnosis or treatment.

Doctors' Visits - Inpatient
Charges for Physician visits to the patient while in the Hospital or Extended Care Facility are covered by This Plan.

Doctors' Visits - Outpatient
This Plan covers medical services received in a Physician's office or received from a Physician in the Covered Member's home.

Durable Medical Equipment
Rental of certain Hospital-type equipment, including a wheelchair, a Hospital-type bed, or mechanical equipment for the treatment of respiratory paralysis is covered by This Plan. Total covered expenses for renting or repairing Durable Medical Equipment shall not exceed its purchase price. If rental or repair cost exceeds purchase price, the cost of purchase will be a covered expense. Equipment or devices not specifically designed and intended for the care and treatment of an Injury or Illness are not covered.

External prosthetic and orthopedic appliances such as artificial legs, arms eyes or larynx or accessories, braces, splints, cervical collars or other orthopedic appliances, required to replace a lost natural body part, or are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or illness or injury are covered subject to precertification. Benefits include charges for the fitting, adjusting, repair or maintenance of such prosthetic and orthopedic appliance. Charges for the replacement of the prosthetic appliance will be covered only if the HPP is shown that: (a) it is needed to a change in the person’s physical condition; or (b) it is likely to cost less to buy a replacement than to repair the existing appliance; or (c) the existing appliance cannot be repaired. Replacement due to technological advancement only is not covered. Only conventional, body-powered, cable-operated prosthetics will be eligible for loss of a limb or congenitally missing limb(s). A myoelectric or utah arm may be considered only for shoulder disarticulation when a cable-operated prosthetic is totally non-functional.

Elective Sterilization Procedures
Vasectomies and Tubal Ligations are covered by This Plan, but the reversal of those operations is not covered.

Emergency Room/Urgent Care and Walk-In Clinic Facility Services
This Plan may cover emergency services for Injuries and Illnesses and Deductible does not apply. The Emergency Co-Pay will be waived when the visit results in an immediate inpatient admission. Expenses incurred by a Non-Network provider will be paid as an Expanded-Network provider if incurred on an Emergency basis as defined on page 65.

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 4 AND PAGE 6

COVERED MEDICAL EXPENSES (Continued)

Fertility Studies and Diagnostic Procedures
Fertility studies and diagnostic procedures are covered to a Calendar Year maximum of $2,000.

Home Health Care Benefit
Home Health Care and Medically Necessary therapies are covered by This Plan.

Hospice Care Benefit
This Plan may cover Hospice Care directed by a Physician for a Terminally Ill Covered Member when the attending Physician certifies life expectancy is 6-months or less.

The program must meet standards set by the National Hospice Organization and be recognized as a Hospice Care program by the HPP Administrator. If such a program is required by the state to be licensed, certified, or registered, it must also meet that requirement.

Hospice Care includes Inpatient Care in a Hospice, Hospital, or home and Outpatient services provided by the hospice, including drugs and medical supplies. Instructional services for care of the patient, counseling, and other supportive services for the family of the dying individual are also covered.

Also covered are charges for bereavement counseling incurred within six (6) months of the Covered Member's death for the Covered Member's surviving spouse and Dependent children who were covered under the HPP on the day immediately preceding the death of the Covered Member.

Hospital Services

Room and Board Charges
This Plan may cover daily Room and Board Charges. The room limit for each day of confinement is limited to the semi-private room rate in the Hospital unit where confined. If no semi-private accommodations are available, charges for a private room will be limited to the semi-private room rate in the Hospital where confined. However, if a private room is Medically Necessary due to contagious disease, it will be covered.

If multiple admissions are incurred within 72 hours of the initial admission, only one Co-Payment will apply.

Inpatient Hospital Services and Supplies
Hospital services and supplies and the non-custodial services of a Nurse, when rendered on an Inpatient basis, are covered by This Plan. Any eligible Inpatient Hospital service and supplies when rendered in a Preferred Provider Network facility, will be paid based on the Preferred Provider Network Schedule of Benefits.

Intensive Care
This Plan may cover confinement in an Intensive Care, cardiac care, or neonatal unit.
Intensive Care must be: (a) ordered by a Physician; and (b) due to a condition that requires special medical and nursing treatment not generally provided to other Inpatients of the Hospital.

Massage Therapy
Massage Therapy may be covered by This Plan only when ordered by a Physician and performed by a Licensed Massage Therapist located in a medical provider’s office or facility and only when the patient demonstrates significant functional gains. Massage Therapy to maintain current levels of functioning is not covered.

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 4 AND PAGE 6

COVERED MEDICAL EXPENSES (Continued)

Mastectomy Procedures. The HPP shall cover the following procedures in the manner as determined in consultation between the attending Physician and the covered Employee or Dependent:

1. Reconstruction of the breast on which a mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

All Precertification and Utilization Review requirements of the HPP will not apply to Surgical and treatment procedures associated with mastectomies of the covered Employee or Covered Dependent.

Maternity Benefit
This Plan may cover Maternity Benefits on the same basis as any other Illness. Covered Expenses include delivery, cesarean, and pre- and post-natal visits.

Complications of Pregnancy are covered on the same basis as any other Illness for Covered Employees, covered Spouses, and covered Dependents.

All mothers and newborns may have a minimum of a 48 hour hospitalization after a normal birth and a hospitalization of a minimum of 96 hours after a cesarean delivery. Patients may make a decision to leave a Hospital sooner. This decision should be mutually agreed upon between the Physician and the mother. Also the "Precertification and Utilization Review Program" requirements for Inpatient Hospital admissions will **not** apply for this minimum length of stay.

Medical Services and Supplies
This Plan may cover Eligible Charges for: (a) oxygen, and rental of equipment required for its use, not to exceed the purchase price of such equipment; (b) blood and/or plasma, if not replaced, and the equipment for its administration; (c) casts, crutches, catheters, colostomy bags, and surgical dressings; (d) the purchase of orthotic devices to be attached to or placed in shoes (but not the shoes themselves) for a medical condition covered by the HPP; (e) purchase of breast prostheses, and two (2) surgical bras in a calendar year, for a breast surgically removed; (f) one wig for hair loss due to cancer treatment; and (g) the initial purchase of eyeglasses or contact lenses, per Medicare guidelines, due to cataract Surgery.

Mental or Nervous Disorders
Benefits will be paid as shown in the Schedule of Medical Benefits, Behavioral Health Benefits for treatment of Mental/Nervous Disorders.

A Mental/Nervous Disorder must be classified in the International Classification of Diseases of the U.S. Department of Health and Human Services and must, according to generally accepted professional standards, be amenable to favorable modification. Treatment must not extend beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 4 AND PAGE 6

COVERED MEDICAL EXPENSES (Continued)

Mental or Nervous Disorders (continued)
Benefits are provided for enrolled Dependents under 18 years of age or an enrolled Dependent 18 years of age or older who is in high school and was diagnosed at 8 years of age or younger with Autism Spectrum Disorder. Benefits are provided for the generally recognized services listed below when prescribed by the treating Physician:

1. well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder;
2. applied behavioral analysis when provided by an individual certified pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491;
3. speech therapy;
4. occupational therapy; and
5. physician physical therapy.

No benefits are provided for court-ordered treatment of Mental/Nervous Disorders or psychiatric disorders unless also medically necessary.

Treatment of Mental/Nervous Disorders must be given under the direction of a Physician and the treatment program must be accredited by The Joint Commission or by equal standards.

Inpatient Treatment
The Plan will pay for eligible charges incurred for room, board, and other usual services while confined as an Inpatient in a Hospital, a Mental/Nervous Treatment Facility, or a Residential Treatment Facility. Physician visits provided during such confinement are also covered.

Outpatient Treatment
The Plan will pay for eligible charges incurred for treatment or service on an Outpatient basis. Benefits include visits to a licensed Physician, psychologist, or mental health professional in an office, a Hospital, a Mental/Nervous Disorder Treatment Facility or a Substance Abuse Treatment Facility.

Newborn Baby Care
This Plan may cover the charges for the care of a Covered newborn Dependent child. Charges must be incurred while such Covered Dependent is confined in a Hospital or on the day of delivery in a licensed Birthing Center. Nursery charges, attending pediatrician charges for the care of a newborn child, normal services and supplies given to well newborn children following birth, charges for services of a certified Nurse Midwife, and charges related to circumcision of a newborn are also covered.

Circumcision is also covered when performed in the physician's office when such procedure is not performed in the Hospital following birth. An office Co-Pay is appropriate. Coverage for Injury or Illness including care or treatment of congenital defects, birth abnormalities, or Premature Birth will be covered on the same basis as any other eligible expense, provided Dependent Coverage is in force at the time Eligible Expenses are incurred.

The standard Inpatient Hospital Co-Payment for the mother shall include the standard admission fee of a covered newborn Dependent child.

Transportation
This Plan may cover the charges incurred in connection with the transportation of a sick or injured newborn infant to the nearest available facility appropriately staffed and equipped to treat an Injury or Illness, including congenital defects, birth abnormalities, or prematurity, when such transportation is certified by the attending Physician as necessary to protect the health and safety of the newborn child.

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 4 AND PAGE 6

COVERED MEDICAL EXPENSES (Continued)

Occupational Therapy
Occupational Therapy performed by a Licensed Occupational Therapist is covered by This Plan. The Therapy must be ordered by a Physician, and the patient must demonstrate significant functional gains. Occupational Therapy for the sole reason of maintaining current level of functioning, therapy to prevent deterioration, or therapy for vocational rehabilitation (i.e., return-to-work skills) are not covered by This Plan.

Office Surgery
This Plan may cover invasive and non-invasive surgeries and procedures performed in a Physician's office. For example, the following surgeries/procedures would be payable under the Office Surgery benefit of this Plan:

Lesion removals (moles, lipomas, warts, etc.)
Cauterization of the cervix
Injection into a joint
Nasal endoscopies
Fetal stress tests
Removal of toenail matrix

Organ or Tissue Transplant Procedures
This Plan covers Eligible Charges incurred by a Covered Member for services and supplies required for the transplant of human solid organs, specifically: heart, heart/lung, lung, double lung, liver, pancreas, kidney, and cornea. Also covered are bone marrow and/or peripheral blood stem cell transplants, transfusion and re-infusion. A transplant must be performed at a transplant facility approved by the American Hospital Association or as approved in writing by the stop-loss carrier.

These benefits are available when a covered person participates in the Special Transplant Program and meets all of the following requirements:

1. Pre-notification of the upcoming transplant must be given by the covered person, their physician or Third Party Administrator as soon as the covered person is identified as a potential transplant candidate.
2. Pre-certification must be obtained from KePRO; and
3. All transplant services must be rendered at a transplant Center of Excellence facility in the preferred transplant network.

If these requirements are not met, Special Transplant Program benefits may be reduced.

General Provisions
Early precertification to KePro must be made as soon as the covered person is identified as a potential transplant candidate.

Self-Funded Group Health Benefits Plans for Florida residents (in "local governmental unit" which means any county, municipality, community college district, school board or special district or any county officer) in accordance with Section 627.652, of the Florida statues, may not exclude coverage for bone marrow transplant procedures recommended by the referring physician and the treating physician under a policy exclusion for experimental, clinical, investigative, educational, or similar procedures contained in any individual or group health insurance policy or health maintenance organization contract issued, amended, delivered, or renewed in this state (Florida) that covers treatment for cancer, if the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncological specialty.

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 4 AND PAGE 6

COVERED MEDICAL EXPENSES (Continued)

Outpatient Surgery Charges
Outpatient Surgery performed in a Hospital, a Freestanding Surgical Unit, an Extended Care Facility, 23-hour observation, or a Physician's office is covered by This Plan.

Room and Board Charges are not covered and recuperation must take place outside the facility.

Covered Charges include Physicians' fees, Anesthesia, and miscellaneous services and supplies necessary for the Outpatient Surgery.

Physical Therapy
Physical Therapy may be covered by This Plan only when ordered by a Physician and performed by a Registered Physical Therapist and only when the patient demonstrates significant functional gains. Physical Therapy to maintain current levels of functioning is not covered.

Physical Therapy visits must be precertified beginning with the first visit; however, a precertification penalty will not apply until visit 13.

After the initial 12 visits, a Treatment Plan must be approved by the HPP if the covered member is to receive coverage for additional services. The Treatment Plan must be filed with the Claims Administrator for the HPP to establish medical necessity and appropriate level of care.

Pre-Admission Testing
Tests performed on an Outpatient basis prior to a planned Hospital admission or Outpatient Surgery are covered by This Plan. Such tests must be ordered by the same Physician who ordered the confinement, must be related to the procedure, and must be recent enough to be useful for the planned admission or Surgery.

The Admission to the Hospital or the scheduled Outpatient Surgery must be confirmed in writing by the attending Physician before the testing occurs; and the tests must be performed in a facility acceptable to the Hospital, must be in place of the same tests which would normally be done while confined in the Hospital, and must not be duplicated in the Hospital.

Second Surgical Opinion Benefit (Voluntary)
The Plan will pay for eligible charges incurred by a Covered Person in obtaining a second and/or third surgical opinion, after he or she has decided to undergo a Surgical Procedure which is covered under this Plan. A second opinion regarding cosmetic surgery, normal obstetrical delivery and Surgical Procedures which require only local anesthesia are not covered.

Benefits include the Physician's charges for the physical examination, laboratory work, x-rays and related tests not previously performed by the original surgeon. If the second opinion does not confirm the original recommendation, the Plan will pay for eligible charges incurred by the Covered Person in obtaining a third opinion.

Speech Therapy
This Plan may cover Speech Therapy performed by a Qualified Speech Therapist. The Therapy must be ordered by a Physician, and the patient must demonstrate significant functional gains. Speech Therapy for the sole reason of maintaining current level of functioning or to prevent deterioration is not covered. If the speech loss or impairment is due to a congenital anomaly, Surgery to correct the anomaly must have been performed prior to the therapy.

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 4 AND PAGE 6

COVERED MEDICAL EXPENSES (Continued)

Substance Abuse
Benefits will be paid as shown in the Schedule of Medical Benefits, Behavioral Health Benefits for treatment of Substance Abuse.

No benefits are provided for court-ordered treatment of mental or psychiatric disorders or Substance Abuse.

Treatment of Alcoholism or Drug Abuse must be given under the direction of a Physician and the treatment program must be accredited by The Joint Commission or by equal standards. This includes The Joint Commission or state-approved Alcoholism rehabilitation programs or licensed Drug Abuse rehabilitation programs.

Inpatient Treatment
The Plan will pay for eligible charges incurred for room, board, and other usual services while confined as an Inpatient in a Hospital, a Substance Abuse Treatment Facility, or a Residential Treatment Facility. Physician visits provided during such confinement are also covered.

Outpatient Treatment
The Plan will pay for eligible charges incurred for treatment or service on an Outpatient basis. Benefits include visits to a licensed Physician, psychologist, or a Substance Abuse health professional in an office, a Hospital or a Substance Abuse Treatment Facility.

Surgery Benefit - Inpatient
This Plan may cover Surgical Procedures and procedures for correcting fractures and dislocations.

The services of an assistant surgeon, provided the assistance is Medically Necessary, are also covered. Eligible Charges for an assistant surgeon are the lesser of the assistant surgeon's fee or 20% of the primary surgeon's fee.

When a Physician performs multiple Surgical Procedures in one operating period through the same natural body opening, or through the same Incision in the same Operative Field, the primary procedure will be covered at 100% of the allowable benefit, the second procedure at 50%, the third procedure at 50%, the fourth procedure at 50% and the fifth procedure at 50%, provided they are not Incidental Procedures. No additional amount will be allowed for an Incidental Procedure when performed in conjunction with other major Surgical Procedures.

If multiple Surgical Procedures are performed through separate natural body openings, or through Separate Incisions in Separate Operative Fields, each Independent Surgical Procedure will be covered at 100% of the allowable benefit.

Sterile surgical supplies after Surgery are also covered.

The Physician's fee for a procedure is deemed to include all post-operative care.

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 4 AND PAGE 6

COVERED MEDICAL EXPENSES (Continued)

Teeth, Gums and Alveolar Process

This Plan may cover the services of a licensed Dentist or dental surgeon for the care or treatment of the teeth, gums, or alveolar process but is limited to:

a. the excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when a lab exam is required;
b. the removal of impacted teeth, including soft tissue, partial bony, full bony, and related services;
c. external incision and drainage of cellulitis;
d. incision of salivary glands or ducts;

1. emergency repair, including surgery, needed to correct accidental injuries to natural teeth or to correct accidental injuries to the jaws, checks, lips, tongue, floor and roof of the mouth; and;
2. anesthesia for any of the above services.

When treatment is necessary as the direct result of an Accidental Injury, eligible Hospital expenses and expenses incurred for the services of a licensed Dentist or dental surgeon are covered, if services are rendered within 72 hours of the accident.

Therapeutic Services

This Plan may cover the following therapeutic services and the materials and services of technicians to administer them: X-ray, cobalt, radium, radioactive isotope, and other acceptable forms of radiation therapy for treatment of proven malignant disease; intravenous and oral chemotherapy for the treatment of proven malignant disease when the drugs used are approved by the Federal Food and Drug Administration.

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 4 AND PAGE 6

MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS

This Plan may not pay for:

1. for hair transplantation and other procedures to replace lost hair or to promote the growth of hair, for the use of Monoxidil, Propecia, Rogaine, or other prescription drugs or medicines used to promote the growth of hair, or for hair replacement devices including but not limited to wigs, toupees and/or hairpieces, **except** that the HPP will provide benefits for a single wig, toupee, or hairpiece if it is required to replace hair lost as a result of chemotherapy or radiation therapy or in the case of hair lost as a result of certain childhood diseases causing permanent hair loss."

2. for eye examinations or eye refractions to determine the correction of vision, eyeglasses, contact lenses or their fitting unless for initial replacement of the lens of the eye after cataract Surgery, eye exercises, vision therapy, fusion therapy, vision aids or orthoptics, or radial keratotomy or other refractive Surgery or related examinations;

3. for hearing aids or the fitting of hearing aids;

4. for Cosmetic Surgery or the reversal or correction of Cosmetic Surgery except for treatment or Surgery for reconstructive Surgery, only if such Surgery is necessary to correct a deformity or to restore or provide normal bodily function lost as a result of an injury or illness; or for reconstructive Surgery due to a congenital disease or anomaly which has resulted in a functional defect of a covered dependent child;

5. for any Physical Therapy, Massage Therapy, Speech Therapy, or Occupational Therapy, where no significant improvement of the condition can be expected as a result of the therapy;

6. for insertion or maintenance of an artificial heart or other artificial organs;

7. for the following care, treatment, or supplies for the feet: orthopedic shoes; diagnosis and treatment of weak, strained, or flat feet, instability or imbalance of the feet, or any tarsalgia, metarsalgia or bunion, other than operations involving the exposure of bones, tendons, or ligaments; treatment, including cutting or removal by any method, of toenails or superficial lesions of the feet, including corns, callouses, and hyperkeratoses, other than the removal of nail matrix or root; however, planter warts will be covered; services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.

8. for any medical treatment, procedure, drug, biological product or device which is deemed experimental or investigational by KePRO, based on the most current reliable evidence;

9. for weight control services including any service to lose, gain or maintain weight regardless of the reason for the service or whether the service is part of a treatment plan for a condition. This exclusion includes, but is not limited to weight control/loss programs; appetite suppressants and other medications, dietary regimens; food or food supplements, exercise programs; exercise or other equipment gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wirings, jejunal bypass, gastric shunts, and procedures designed to restrict the ability to assimilate food;

10. for manipulation of the spine requiring Anesthesia;

11. for Non-Surgical Spinal Decompression;

12. for transplants, except as stated in the provision entitled “Organ or Tissue Transplant Services”;

MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS (Continued)

13. for in-vivo or in-vitro fertilization, or medical services or supplies for artificial insemination;

14. for expenses or services of a surrogate mother;

15. for sex change Surgery; penile prosthetic implant; services, therapy, or counseling for sexual or gender dysfunctions or inadequacies or for the reversal of any elective sterilization procedure;

16. for immunotherapy for recurrent abortion;

17. for mechanical contraceptive devices and implantable contraception medications not approved by the FDA;

18. for routine physical services in the absence of or unrelated to definite symptoms of Illness or Injury, except as specified under the "Preventive Services" provision of This Plan with the exception of Contraceptive Management, covered under Physician Visits - Outpatient;

19. for vitamin or mineral supplements, or fluoride drugs;

20. for holistic medicine, acupuncture, hypnosis, biofeedback, or forms of self-care or self-help;

21. for marital or family counseling;

22. for telephone consultations, failure to keep scheduled appointments, completion of claim forms, or providing medical information necessary to determine Coverage;

23. for educational or vocational testing or training, or job training;

24. for Custodial Care;

25. for Hospital services and supplies when confinement is primarily for diagnostic testing purposes or Physical Therapy;

26. for the purchase or rental of motorized transportation equipment, except when the patient meets Medicare guidelines, escalators or elevators, saunas or swimming pools;

27. for personal hygiene and convenience items such as but not limited to haircuts, shampoos and sets, guest meals, radio/television rentals, air purifiers or air conditioners, room humidifiers, exercise cycles or other physical fitness equipment, water purifiers, hypo-allergenic pillows or mattresses, or waterbeds;

28. for charges for medical services and supplies that are in excess of the negotiated rate of the Preferred Provider Network for services received in the Network; or charges that are in excess of the Usual and Customary, and Reasonable (UCR) charges for medical services provided outside the Network;

29. for medical services or supplies for which benefits are not paid due to the Deductible or Co-Insurance Percentage provisions of This Plan;

MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS (Continued)

30. for any medical treatment not Medically Necessary;

31. for medical services rendered outside the continental United States of America or its territories except for Accidental Injury or a Medical Emergency;

32. for claims not received within twelve (12) months from the date services were incurred;

33. for any medical services or supplies not prescribed by a Physician;

34. for any expense denied by the primary health plan because the claim did not comply with the rules governing that plan of benefits;

35. for charges covered by extended benefits from another group health plan;

36. for charges resulting from any intentionally self-inflicted Injury or suicide or attempted suicide while sane or insane unless as a result of a physical or mental medical condition or act of domestic violence;

37. for professional medical services and supplies rendered by the Employee, Employee's spouse, or the children, brothers, sisters, parents, or grandparents of either the Employee or the Employee's spouse;

38. for charges which you are not legally required to pay, or which you would not have to pay if you were not covered under This Plan, or were incurred while you are not covered under This Plan, or are discounted;

39. for or in connection with an Injury or Illness for which the Covered Member is entitled to benefits or payments under Automobile Personal Injury Protection Insurance issued pursuant to any No-Fault-type automobile reparations ordinance or statute;

40. for care, treatment, services, and supplies received in a Hospital or facility owned or operated by the United States Government or any of its agencies, except that charges incurred at either a Veterans Administration Hospital for non-service-related disabilities, or a military Hospital for all disabilities will be directly reimbursed to the Hospital upon demand and then only to the extent that the charges are eligible and payable under the HPP;

41. for care, treatment, services, and supplies provided or paid for by any government plan or law not restricted to its own civilian Employees and their Dependents, except that this does not apply to Medicaid; and does not apply when otherwise prohibited by law;

42. for any injury or sickness which the covered employee or covered dependent is entitled to benefits under any Workers' Compensation or Occupational Disease law or act, whether or not any coverage for such benefits is actually in force;

43. for charges incurred due to war, or any act due to war, if declared or not; or incurred as the result of Injury caused by participation in a civil insurrection or a riot;

44. for any service or supply which is specifically limited or excluded under any other portion of This Plan;

MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS (Continued)

45. for dental services and supplies except as specified under the “Teeth, Gums and Alveolar Process” provision of This Plan;

46. for diabetic supplies not purchased through the Prescription Drug Program;

47. for prescribed medications not purchased through the Prescription Drug Program;

48. for routine colonoscopies for covered members under age 50;

49. for charges related to genetic testing unless medically necessary subject to review by KePRO.

PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS

This Plan will not pay for:

1. any drug, biological product, or device which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which lacks such approval at the time of its use or proposed use by the Food and Drug Administration;

2. any drug or biological product categorized as a Treatment Investigational New Drug (IND) by the U.S. Food and Drug Administration or any drugs bearing the label "Caution – limited by federal law to investigational use," or experimental drugs;

3. any drugs used primarily for cosmetic purposes (ex: hair restoration, anti-wrinkle);

4. medications for acne treatments, except for all patients 25 and under are covered;

5. any over-the-counter medications, excluding insulin;

6. therapeutic devices or appliances, including but not limited to syringes, hypodermic needles, support garments, and other non-medical substances. Covered diabetic supplies are limited to needles, syringes, glucose, glucose monitors, and chemical strips;

7. infertility medications;

8. migraine medications are covered with specific quantity limitations;

9. pain medications are covered with specific quantity limitations;

10. insomnia medications are covered with specific quantity limitations;

11. male impotency medications are covered with limits: 9 tabs per month at retail and 27 tabs per 90 days supply at mail;

12. mechanical contraceptive devices, including but not limited to intrauterine devices, and implantable contraception medications not approved by the FDA;

13. refilling a Prescription in an amount greater than that authorized by the prescriber;

14. appetite suppressants, diet medications, or medications prescribed for weight control;

15. filling or refilling of Prescriptions not in compliance with applicable state and federal laws, rules, and regulations;

16. quantities in excess of a 30-day supply for retail Pharmacy purchases and a 90-day supply for Retail 90 and Catamaran Rx Mail Service Pharmacy purchases;

17. prescription drugs which may be properly received without charge under local, state, or federal programs, including Workers' Compensation;

18. diabetic medications are covered with specific quantity limitations;

19. prescriptions filled at a non-network pharmacy unless for emergency reasons.

**Covered and Excluded drugs and categories are subject to change without notice.*

GENERAL CLAIM PROVISIONS
CLAIM DENIAL AND HOW TO APPEAL A DENIAL OF BENEFITS

If you believe a claim was improperly settled, in whole or in part, you have the right to appeal the claim settlement by making a written request for review to HealthSmart, the Claims Administrator, within 180 days of notification.

You have the right to review this Summary Plan Description and other papers affecting the claim. You also have the right to have a representative act on your behalf in the appeal.

The HPP will review the processed claim and inform you in writing as to their decision within:

- 72 hours for urgent claims;
- 30 days for pre-service claims;
- 60 days for post-service claims;

of the receipt of the request for review. In the event a claim is denied (you receive a notice of Adverse Benefit Determination) the Covered Person will be advised of the reason for the denial with specific reference to the HPP provision(s) on which the denial was based and any additional material or information needed for further review of the claim.

If you are not satisfied with the first review, a written request for a second review may be submitted. You must submit your request for a second review keeping within the 180 days of the initial notification. The request should state, in clear and concise terms, the reason for disagreement with the way the claim was processed.

When the written request is received, the claim will be reviewed again and the results of this review furnished to you in writing keeping within the same timeframes, as stated above, that applied to the initial review of the claim.

If, after exhausting your internal appeals, you are not satisfied with the determination made by HealthSmart, or if HealthSmart fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of the determination. External Reviews of adverse benefit determination are performed by an accredited Independent Review Organization (“IRO”) at no additional cost to you under the Federal External Review Program.

Federal External Review Program

An IRO is separate and apart from the Plan and is available for most Adverse Benefit Determinations. The availability of this review is collectively referred to as “the federal external review process.” There are two types of external reviews, “standard” external review and “expedited” external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by HealthSmart of the request.
- A referral of the request by HealthSmart to the IRO.
- A decision by the IRO.

1. If you want to have a Claim that was denied by the Plan reviewed externally, you (or your representative) must file a request for an external review within four (4) months after the date of receipt of notice of an Adverse Benefit Determination. The request for an external review must be made in writing on the form made available by, and submitted to HealthSmart.

2. Within five (5) business days after receipt of the request, HealthSmart will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- The Covered Person is (or was) covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, the Covered Person was covered under the Plan at the time the health care item or service was provided;
- The Adverse Benefit Determination is not based on the fact that the Covered Person was not eligible for coverage under the Plan;
- The Covered Person has exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); and
- The Covered Person has provided all the information and forms required to process an external review.

The Covered Person or their representative will be notified by HealthSmart of the results of the preliminary review of the request within one (1) business day of the Claim Administrator's completion of the preliminary review.

If the request is complete but not eligible for external review:
- The notice will state the reasons for the request not being eligible for external review and will provide other important information.
- If the request is incomplete, the notice must describe the information, materials, etc. needed to complete the request.

The Covered Person or their representative will then be provided time to perfect the request; the longer of the initial four (4) month period within which to request an external review or, if later, forty-eight (48) hours (or such longer period specifically identified in the notice) after the receipt of the notice.

If a request complete and eligible for external review:
- HealthSmart will assign an IRO to conduct the external review.
- The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.
- The IRO will notify the Covered Person (or their representative) in writing of the request's eligibility and acceptance for external review and that it has been assigned to conduct the external review.
- The Covered Person (or their representative) may submit additional information in writing to the IRO within ten (10) business days of the IRO's notification that is has been assigned the request for external review.
- The IRO must consider this additional information when conducting the external review.

HealthSmart will provide to the IRO documents and any information considered in making the Adverse Benefit Determination in a timely manner. The IRO will review all of the information and documents received expeditiously. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

- The Covered Person's medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the HealthSmart
- Reports or documents submitted by the Covered Person, or the Covered Person's treating Healthcare Provider;
- The terms of the Covered Person's summary plan description;
- Evidence-based practice guidelines;
- Any applicable clinical review criteria developed and used by the Claims Administrator; and
- The opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

In making its decision, the IRO is not bound by the Plan's prior determination.

3. The IRO will provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision. The notice of the final external review decision shall be provided to the Covered Person (or someone on the Covered Person's behalf) and the Plan. To the extent the final external review decisions reverses the Plan's decision (as was reflected in the Adverse Benefit Determination), the Plan shall follow the final external review decision of the IRO.

Expedited External Review

Under certain circumstances, an "expedited" external review may be requested. An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

1. The Covered Person (or someone on the Covered Person's behalf) may request an expedited external review when:

- An Adverse Benefit Determination involves a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Covered Person's life, health, or ability to regain maximum function, and a request for an expedited internal appeal has been filed; or
- An Adverse Benefit Determination involves (i) a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Covered Person's life, health, or ability to regain maximum function, or (ii) an admission, availability of care, continued stay, or health care item or service for which the Covered Person received emergency services, but have not been discharged from a facility.

The request for an expedited external review must be made in writing on the form made available by the HealthSmart and submitted to the Claims Administrator.

2. Immediately upon receipt of the request for an expedited external review, the HealthSmart will determine whether the request meets the requirements described above for a standard external review and will notify the Covered Person (or someone on the Covered Person's behalf) of its eligibility for expedited determination.

3. When HealthSmart determines that the Covered Person's request is eligible for external review, an IRO will be assigned as described above for a standard external review.

4. HealthSmart will provide all necessary documents and information considered in making the Adverse Benefit Determination to the IRO by any available expeditious method.

5. In reaching its decision, the IRO must consider the information or documents as described above for a standard external review and the IRO is not bound by the Plan's prior determination.

6. The IRO will provide notice of the final external review decision as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the IRO's notice of decision is not in writing, the IRO must provide written confirmation of the decision within forty-eight (48) hours to the Covered Person (or someone on the Covered Person's behalf) and the Plan. To the extent the final external review decision

reverses the Plan's decision (as was reflected in the Adverse Benefit Determination), the Plan shall follow the final external review decision of the IRO.

The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to HealthSmart.

You may contact HealthSmart at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

If you believe the pre-certification of a procedure as outlined on page 4 has been unfairly denied, you have the right to request reconsideration of this decision by making a written request to Preferred KePRO, the utilization management provider, within 30 days of receipt of the denial. If you are not satisfied with their determination and wish to pursue your appeal, you must complete the Authorization Form found in this Summary Plan Description or on the County ENN page, before you can request assistance from the HPP Administrator, Personnel Division Benefits Section.

If you believe that a prescription was improperly filled or you were charged an incorrect co-payment, you have the right to appeal this decision by making a written request to Walgreens Health Initiatives, the prescription benefit manager, within 30 days of the claim. If you are not satisfied with their determination and wish to pursue your appeal, you must complete an Authorization Form found in the back of the Summary Plan Description or on the County ENN page, before you can request assistance from the HPP Administrator, Personnel Division Benefits Section.

Before any member of the Personnel Division Benefits Section can assist a health plan participant which concerns protected health information under the Federal Privacy Rules, the participant must sign the Authorization Form found in the back of the Summary Plan Description or on the County ENN page.

GENERAL CLAIM PROVISIONS (Continued)

Assignment of Benefits
Under normal conditions, benefits are payable to you, and can only be paid directly to another party upon signed authorization from you. All benefits payable by This Plan may be assigned to the provider of services, or supplies at your option. Payments made in accordance with an assignment are made in good faith and discharge the HPP's obligation to the extent of the payment.

If conditions exist under which a valid release, or assignment cannot be obtained, This Plan may make payment to any individual, or organization that has assumed the care, or principal support for you and is equitably entitled to payment. This Plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by This Plan. Any payment made by This Plan in accordance with this provision will fully release This Plan of its liability to you.

Clerical Error
If a clerical error is made, it will not affect the Coverage to which the Covered Member is entitled. A fair adjustment of premiums shall be made, from the date the member notifies the HPP Administrator in writing, when a clerical error has occurred, or a delay in making entries in the records pertaining to the Coverage under the HPP is found. Such an error, or delay will neither void Coverage that is otherwise validly in force, nor continue Coverage beyond the date that Coverage would otherwise terminate.

Conformity to Statutes
This Plan will conform to all applicable State and Federal statutes.

Right to Investigate Claims
The HPP Administrator will have the right to request, or release any medical information it deems necessary to properly process a claim.

The HPP Administrator has the right, and opportunity to examine, at its expense, any person whose Illness, or Injury is the basis of any claim, when and as often as reasonably required and, in the event of death, to obtain an autopsy, unless prohibited by law.

Statements not Warranties
In the absence of fraud, all statements made by the Employer or by a Covered Employee are deemed representations, and not warranties. No statement made by the Employer, or by an Employee for the purpose of obtaining Coverage, will be used to avoid such Coverage, or reduce benefits unless the statement is in writing, and is signed by the Employer, or the Employee and a copy is sent to the Employer, the Employee, or their beneficiary.

Time Limit for Submitting Claims
All claims should be submitted as soon as possible after the charges are incurred. In any event, all claims must be submitted within one (1) year of the date charges are incurred to be considered eligible for payment. A charge will be deemed incurred on the date services are actually rendered, or supplies are actually received. Additional information requested on a claim must be received one (1) year from the date requested.

Payment of Claims
Claims for all benefits due under This Plan will be processed promptly after a properly completed claim has been received. Complete “Urgent” claims will be processed as soon as possible after receipt not to exceed 72 hours.

GENERAL CLAIM PROVISIONS (Continued)

Complete “Pre-Service” claims will be processed within 15 days and complete “Post-Service” claims will be processed within 30 days of receipt.

A claim involving **“Urgent”** Care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or

2. In the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

A **“Pre-Service”** claim means any claim for a benefit under the HPP with respect to which the terms of the HPP condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A **“Post-Service”** claim means any claim for a benefit under the HPP that is not a “Pre-Service” claim.

COORDINATION OF BENEFITS

The benefits that are payable under This Plan for medical expenses will be coordinated with any other plans that provide the same benefits, so that not more than 100% of the allowable expenses will be covered. The County has the right to gather data, recover sums paid, or repay any party in order to administer the Coordination of Benefits.

General Provision
When a Covered Member, and/or his Dependents are covered under more than one group health plan, the combined benefits payable by This Plan, and all other group plans will not exceed 100% of the eligible expense incurred by the individual. The plan assuming primary payor status will determine benefits first without regard to benefits provided under any other group health plan.

When This Plan is the secondary payor, it will reimburse, subject to all Plan provisions, the balance of remaining Eligible Expenses, not to exceed normal Plan liability.

For purposes of coordination, eligible expense means any usual and customary charge considered in part or full by at least one of the plans. However, any expense denied by the primary carrier because the claimant did not comply with the rules governing the primary plan of benefits will not be considered an eligible expense under This Plan.

Other Group Plans
This Plan coordinates with other plans according to the following rules:

1. Any group health plan which does not contain a coordination of benefits provision will be primary.
2. A plan covering a person as an Employee will be primary over a plan covering the same person as a Dependent.
3. A plan covering a person as an Active Employee will be primary over a plan covering the same person as either a Retiree or terminated individual.
4. When a person is an Active Employee under more than one plan, the plan covering the individual for the longer period of time will be primary.
5. A plan covering a person as a Dependent child of non-divorced or non-separated parents will be primary according to which parent has the earlier birth date (month and day) in the year. If both parents have the same birth date, the plan covering the child for the longer period of time will be primary.

Children of Divorced or Separated Parents
When all plans covering a person as a Dependent child of divorced or separated parents contain a coordination of benefits provision, This Plan coordinates with other plans according to the following rules:

1. If there is a court order establishing which parent has financial responsibility for the child's health care expenses, that parent's plan (assuming it covers the child as a Dependent), will be primary.
2. If there is no court order, and the parent with legal custody has not remarried, that parent's plan is primary (assuming it covers the child as a Dependent).
3. If there is no court order, and the parent with legal custody has remarried, the plans that cover the child as a Dependent will pay benefits in the following order:

COORDINATION OF BENEFITS (Continued)

a. The plan of the parent with legal custody;
b. The plan of a stepparent who is the spouse of the natural parent having legal custody;
c. The plan of the parent without custody.

If none of the rules listed above establish an order of payment, the plan which has covered the person the longest will be primary.

HMO's
There are special coordination of benefit rules that affect Dependents covered under Health Maintenance Organizations (HMOs).

When primary Coverage is through an HMO sponsored by another employer, and This Plan is secondary, This Plan's secondary Coverage will not provide Coverage if you or your Dependents fail to comply with the HMO's regulations regarding providers and services.

The combined benefits from both the HMO plan and This Plan will not total more than the amount This Plan would have paid alone.

Integration of Benefits with Medicare
For an Active Employee who is age 65 or over the benefits payable under This Plan will be his or her primary health coverage unless he or she elects, in writing, to have Medicare as primary coverage. Any Employee who elects Medicare as primary coverage will not be covered for health coverage under This Plan, nor will any of his or her Dependents.

For a Spouse of an Active Employee who is covered as a Dependent under This Plan and who is age 65 or over, the benefits under This Plan will be his or her primary health coverage unless he or she elects, in writing, to have Medicare as primary coverage. Any Dependent Spouse who elects Medicare as primary coverage will not be covered under This Plan.

For an Active Employee who is totally Disabled or a totally disabled Dependent who is under age 65, the benefits under Medicare will be secondary to any benefits payable under This Plan.

For Covered Retirees and their Spouses who are eligible to enroll under Part A or Part B of Medicare, the benefits payable under This Plan will be secondary and will be reduced by the amount of any benefits payable under Medicare, which will be primary, whether or not the Covered Member has enrolled in Part A or Part B of Medicare.

In the event a Covered Person is also eligible for Medicare due to dialysis treatment, the Plan will be primary during the coordination period (currently the first 30 months of dialysis treatment). Thereafter, Medicare will be primary.

Automobile Insurance
Benefits payable under This Plan will be secondary to benefits which a Covered Member has, or could have, received from any no-fault automobile insurance statute, without regard to the purchase of such insurance or any Deductible. This Plan will pay as if the Covered Member's "No Fault" insurance is in effect without a Deductible.

COBRA Coverage
Cobra coverage is secondary to any other applicable coverage.

COORDINATION OF BENEFITS (Continued)

Right to Receive and Release Needed Information
The HPP Administrator will have the right to obtain or give information needed to administer this Plan or coordinate benefit payments with other plans. This can be from or to any other insurance company, organization or person. Notice or consent will not be needed to do this.

Any person who claims benefits must furnish the information necessary to coordinate benefit payments to the HPP Administrator. If you do not provide the information needed to apply these rules and determine the benefits payable within one year from date of service, your claim for benefits will be denied.

Right to Make Payment
The HPP Administrator reserves the right to pay any other organization as needed to properly carry out this provision. These payments that are made will be made in good faith, and will be considered benefits paid under This Plan. Also, these payments discharge the HPP Administrator from further liability, to the extent the payments are made.

Right of Recovery
If more benefits were paid than should have been paid, the right to recover the excess amount will be exercised. This can be from the person for whom the payments were made, or from an insurance company, or organization to whom the payment was made.

Further, whenever payments have been made based on fraudulent information provided by a Covered Member, This Plan has the right to withhold payment on future benefits until the overpayment is recovered.

EXTENSION OF BENEFITS AFTER PLAN TERMINATION

The benefits payable during any period of extension may be subject to the regular benefit limits of This Plan, but shall provide no lesser benefit limits.

Medical
If This Plan terminates while a Covered Member is Totally Disabled, benefits will be extended for charges incurred after that date. The Covered Member must provide written notice to the HPP of their intention to receive extended benefits within 31-days of the date This Plan terminates. Coverage for the disabling condition will continue without any Employee contribution.

Extended Benefits are payable only for those expenses incurred:
1. for the same Injury or Illness which caused the Covered Member to be Totally Disabled;
2. while the person remains Totally Disabled; and
3. during the first 12-months after the date Coverage terminates under the medical portion of This Plan.

Dental
If This Plan terminates while a Covered Member is receiving dental treatment due to a specific Injury, or Illness which occurred while the Covered Member was covered under This Plan, Covered Dental Expense Benefits will be extended for the first 90-days after the date Coverage terminates under the medical portion of This Plan.

Maternity
If This Plan terminates while a Covered Member is pregnant, Covered Expense Benefits will be extended for the period of the Pregnancy.

SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY

PROVISION

This section describes the HPP's right to seek reimbursement of expenses that are paid by the HPP on behalf of you or your Covered Dependents if those expenses are related to the acts of a third party (for example, if you are involved in an automobile accident or are injured in a place of business). The HPP may seek reimbursement of these expenses from any recovery you or your Covered Dependent may receive from the third party or another source, including from any insurance proceeds, settlement amounts or amounts recovered in a lawsuit. Subrogation and reimbursement rights also exist for any claim you or a covered dependent makes seeking any recovery for benefits under an insurance policy providing under-insured or uninsured motorist benefits. The terms of the HPP's reimbursement rights are described below:

If a Covered Person incurs expenses covered by the HPP as a result of the act of a third party (person or entity), the Covered Person may receive benefits pursuant to the terms of the HPP. However, the Covered Person is required to refund to the HPP to the maximum extent provided by law a settlement, judgment, and lawsuit or otherwise as a result of the act). The Covered Person may be required to:

a) Execute an agreement provided by the County or the Claims Administrator acknowledging the HPP's right of recovery, agreeing to repay any claims paid by the HPP, pledging amounts recovered by the Covered Person from the third party as security for repayment of any claims paid by the HPP, and to the extent provided below, assigning the Covered Person's cause of action or other right of recovery to the HPP. If the Covered Person fails to execute such an agreement, the Covered Person, by filing claims (assigning benefits or having claims filed on his behalf) related to such act of a third party, shall be deemed to have agreed to the terms of this reimbursement provision;

b) Provide such information as the County, or the Claims Administrator may request;

c) Notify the Employer and the Claims Administrator, in writing, by copy of the complaint or other pleading, of the commencement of any action by the Covered Person to recover damages from a third party;

d) Agree to notify the County and/or the Claims Administrator of any recovery;

e) The County shall be entitled to repayment of medical bills incurred as the result of any accident to the maximum amount allowed by applicable law.

The HPP's right to recover the benefits shall apply to the entire proceeds of any recovery by the Covered Person to the extent provided by law. This includes any recovery by judgment, settlement, arbitration award or otherwise.

The HPP shall have a lien against the proceeds of any recovery by the Covered Person and against future benefits due under the HPP in the amount of any claims paid to the maximum extent provided by law. The lien shall attach as soon as any person or entity agrees to pay any money to, or on behalf of, any Covered Person that could be subject to the HPP's right of recovery, if and when, received by the Covered Person. If the Covered Person fails to repay the HPP from the proceeds of any recovery, the HPP Administrator may satisfy the lien by deducting the amount from future claims otherwise payable under the HPP.

SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY
PROVISION (Continued)

If the Covered Person fails to take action against a responsible third party to recover damages within one year, or within 30 days after the HPP requests him/her to do so, the HPP shall be deemed to have acquired, by assignment or subrogation, a portion of the Covered Person's claim equal to the amounts the HPP has paid on the Covered Person's behalf. The HPP may thereafter commence proceedings directly against any responsible third party. The HPP shall not be deemed to have waived its rights to commence action against a third party if it fails to act after the expiration of one year, nor shall the HPP's failure to act be deemed a waiver or discharge of the lien described above.

The Covered Person shall cooperate fully with the HPP in asserting claims against a responsible third party, and such cooperation shall include, where requested, the filing of suit by the Covered Person against any responsible third party. The HPP shall not be deemed to have waived its rights to commence action against a third party if it fails to act after the expiration of one year, nor shall the HPP's failure to act be deemed a waiver or discharge of the lien described above.

The Covered Person shall cooperate fully with the HPP in asserting claims against a responsible third party, and such cooperation shall include, where required, the filing of suit by the Covered Person against a responsible third party and the giving of testimony in any action by the HPP. The Covered Person's failure to cooperate with the HPP is considered a breach of contract. If a Covered Person fails or refuses to cooperate in connection with the assertion of claims against a responsible third party, the HPP Administrator may deny payment of claims and treat prior claims paid as overpayments recoverable by offset against future Plan benefits or by other action of the HPP Administrator. If the HPP incurs attorney fees and costs in order to collect funds. The HPP has the right to recover those fees and cost from the Covered Person.

In addition, the HPP has a right to recover benefits that were paid in error (e.g., benefits paid to/for an ineligible person), or benefits that were obtained through fraudulence, as determined by the Claims Administrator. Benefits may be recovered by either direct payment to the HPP by the Covered Person or a beneficiary (through voluntary payments, legal action, or by an offset of future benefits equal to the amount of the overpayment.

COBRA CONTINUATION COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Covered Employees and/or their Covered Dependents described below (called "Qualified Beneficiaries") are entitled to elect to purchase a temporary continuation of health Coverage (called "Continuation Coverage") at group rates in certain instances (called "qualifying events") when Coverage under the HPP would otherwise end.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs.

An Employee covered by the HPP has a right to elect Continuation Coverage if Coverage is lost because of a termination of employment (for reasons other than fraud or material misrepresentation) or a reduction in hours of employment.

The Covered Dependent who is the spouse of a Covered Employee has a right to elect Continuation Coverage (even if the Employee chooses to decline Continuation Coverage) if the Covered Dependent loses group health Coverage under the HPP for any of the following four reasons:

1. The death of the Employee;

2. A termination of the Employee's employment (for reasons other than fraud or material misrepresentation) or reduction in the Employee's hours of employment;

3. The divorce or legal separation, where recognized, from the Employee; or

4. The Employee becomes entitled to benefits under Medicare.

In the case of a Covered Dependent who is a child of a Covered Employee, such child has the right to elect Continuation Coverage (or the Employee’s spouse may elect Continuation Coverage on behalf of the child, even if the Employee chooses to decline Continuation Coverage) if group health Coverage under the HPP is lost for any of the following reasons:

1. The death of the Employee;

2. A termination of the Employee's employment (for reasons other than fraud or material misrepresentation) or a reduction in the Employee's hours of employment;

3. The Employee's divorce or legal separation, where recognized;

4. The Employee becomes entitled to benefits under Medicare; or

5. The child ceases to be a "Dependent child" under the HPP.

Qualified Beneficiaries have the same rights as similarly situated active employees to change Coverage options and Coverage levels during Open Enrollment or if he experiences a Change in Status or Special Enrollment event.

ELECTING CONTINUATION COVERAGE. Provided you or your Covered Dependents have provided any required notice to the HPP Administrator (see below), you or your Covered Dependents will be notified of the right to continue Coverage and provided with the necessary information to complete an election.

COBRA CONTINUATION COVERAGE (Continued)

You and your Covered Dependents will have 60 days from the date the notice of the right to Continuation Coverage is received (or, if later, 60 days from the date coverage is lost) to complete an election of Continuation Coverage. If the election is not completed within the 60-day period, you will not have Continuation Coverage and will have no further rights to elect such coverage.

Each Qualified Beneficiary may purchase Continuation Coverage by completing and returning the appropriate election forms.

ADDING NEW DEPENDENTS. Children born to, adopted by, or placed for adoption with, the Covered Employee during the period of Continuation Coverage will be considered Qualified Beneficiaries and may also receive Continuation Coverage provided they are added within the time required by the HPP after the birth, adoption or placement for adoption.

Other than a child born to, adopted by, or placed for adoption with a Covered Employee during the COBRA period, spouses and dependents added during the COBRA coverage period are not Qualified Beneficiaries, even though the new spouse or dependent may be eligible to be added to the Coverage for the balance of the COBRA coverage period. The Covered Employee must enroll the new spouse and/or dependent within 31 days after the marriage, birth, adoption, or placement for adoption. If COBRA coverage ceases for the Covered Employee before the end of the maximum COBRA coverage period, COBRA coverage also will end for a newly added spouse or dependent child. However, COBRA coverage can continue for a newly added newborn child, adopted child, or child placed with the Covered Employee for adoption until the end of the maximum COBRA coverage period.

If while the Covered Employee is enrolled in Continuation Coverage, his or her spouse or dependent loses coverage under another group health plan, the Covered Employee may add the spouse or dependent to his or her coverage for the balance of the Continuation Coverage period, provided the eligible dependent meets the requirements for special enrollment as described in the “SPECIAL ENROLLMENT” section of this Plan.

Continuation Coverage may also apply to certain covered retirees and their covered dependents in the event of the Employer's bankruptcy under Title 11 of the U.S. Code. Special rules apply for this event.

COVERED PERSON’S NOTICE REQUIREMENTS. Under group health plan rules and COBRA law, the Employee, spouse, or other family member has the responsibility to notify the HPP Administrator (County of Volusia, Personnel Division) at:

County of Volusia
Personnel Division – Benefits Section
230 N. Woodland Blvd., Suite 262
Deland, FL 32720

386 736-5951 - Deland
386 257-6029 - Daytona Beach
386 423-3300 - New Smyrna

of a divorce, legal separation, where recognized, or a child losing dependent status under the HPP. To protect the Covered Person’s Continuation Coverage rights in these situations, this notification must be made within 60 day from whichever date is later, the date of the event or the date on which health plan coverage would be lost under the terms of the HPP because of the event.

COBRA CONTINUATION COVERAGE (Continued)

NOTICE PROCEDURES. Procedures for making proper and timely notice are listed below.

1. Contact the Human Resources Department and request a Qualifying Event Notification Form;
2. Complete the Qualifying Event Notification Form;
3. Make a copy of the form for your records;
4. Attach the required documentation depending upon the qualifying event;
5. Hand deliver or mail the notification form to the address listed on the form and document your mailing; and
6. Call within 10 days to insure the notification form has been received.

If this notification is not completed according to the outlined procedures and within the required 60-day notification period, then rights to Continuation Coverage based on the occurrence of the event will be forfeited. In addition, failure to notify and thereby causing the HPP to continue coverage of an individual who has in fact become ineligible may be considered fraud on the part of the Employee.

The Covered Person must also notify the HPP Administrator of the current address of the individual losing coverage. This is the address where the COBRA notice will be sent. Once it is notified, the Claims Administrator will, in turn, notify the eligible COBRA participant that he or she has the right to elect Continuation Coverage.

EMPLOYER'S NOTICE REQUIREMENTS. If the qualifying event is a termination of employment, reduction in hours, death, enrollment in Medicare (Part A, Part B, or both) or a commencement of a bankruptcy proceeding, the Covered Person will be notified that he or she has the right to elect Continuation Coverage. The eligible COBRA participant has 60 days from the date of the COBRA notice (or, if later, 60 days from the date Coverage is lost because of one of the qualifying events described above) to elect Continuation Coverage.

TRADE ADJUSTMENT ASSISTANCE. An Employee may have the right to a second COBRA election period if the Employee was entitled to elect COBRA coverage and did not do so during the original COBRA election period. To qualify, the Employee must be receiving trade adjustment assistance (eligibility requires a government certification under the 1974 Trade Act) and must have lost his or her Coverage under the HPP because of a job loss that resulted in his or her eligibility for trade adjustment assistance. The Employee's new 60-day COBRA election period will begin the first day of the month in which he or she begins receiving trade adjustment assistance, but it will not extend more than six months after his or her initial loss of Coverage under the HPP. If the Employee elects COBRA coverage during this second election period and after the end of the initial election period, his or her Continuation Coverage will begin on the first day of the second election period. The Employee's Continuation Coverage will not be retroactive to the date of the initial loss of Coverage

TYPE OF COVERAGE. If timely and properly elected and paid, Continuation Coverage will be provided to Qualified Beneficiaries in a manner identical to Coverage provided under the HPP to similarly situated Covered Persons who are not Qualified Beneficiaries.

COBRA CONTINUATION COVERAGE (Continued)

LENGTH OF CONTINUATION COVERAGE. The length of Continuation Coverage depends upon the type of qualifying event and who the Qualified Beneficiary is. If you are on an approved military leave that lasts longer than 30 days, your Continuation Coverage can last up to 24 months. In the case of a loss of coverage due to the end of employment or the reduction in hours of employment, Continuation Coverage can last up to 18 months. In the case of a loss of coverage due to the Covered Employee's death, divorce or legal separation, the Covered Employee's becoming entitled to Medicare or a dependent child ceasing to qualify as a Dependent under the terms of the HPP, Continuation Coverage may last for up to 36 months (provided that the Qualified Beneficiary submitted written notice of divorce, legal separation or dependent child ceasing to be a dependent within 60 days of the later of the date of the event or the date coverage is lost as a result of the event). When the qualifying event is the end of employment or reduction in hours of employment, and the Covered Employee became entitled to Medicare less than 18 months before the qualifying event, COBRA coverage for Qualified Beneficiaries (other than the Employee) who lose coverage as a result of the qualifying event can extend up to 36 months after the date of Medicare entitlement.

SECOND QUALIFYING EVENTS. The maximum duration of Continuation Coverage based on termination of employment or reduction in hours may be extended from 18 months to 36 months if a second event entitling a Covered Dependent to Continuation Coverage (such as a death, divorce, legal separation (where recognized), the Employee's Medicare entitlement or a child losing Dependent status under the HPP) occurs during that 18-month period (or the first 29 months of continuation coverage in the case of a disability extension). To qualify for this extension, the Employee or Covered Dependent must notify the Employer within 60 days after the second event. In providing this notice, you must follow the notice procedures specified above. You are entitled to an extension only if the event would have caused a spouse or dependent child of an active employee to lose coverage under the HPP. If the Employee or Covered Dependent does not notify the Employer within the 60-day period, the Covered Dependent will not be entitled to extend the maximum period from 18 months to 36 months.

DISABILITY DETERMINATION. For certain disabled Qualified Beneficiaries, Continuation Coverage may be available for up to a total of 29 months from the date of the qualifying event. If you or your Covered Dependent elect Continuation Coverage for reasons due to termination of employment or reduction of hours, and are deemed disabled by the Social Security Administration before, on, or within 60 days of the date the Continuation Coverage became effective, you and your Covered Dependents may be eligible for up to an additional 11 months of Continuation Coverage. You must notify the Claims Administrator within 60 days of the date of the Social Security disability determination and before the end of the initial 18-month COBRA period. You must also notify the Claims Administrator within 30 days of the Social Security Administration's determination that you (or your Covered Dependent) are no longer disabled.

If the individual entitled to the disability extension (described in the preceding paragraph) has nondisabled family members who have Continuation Coverage due to the same qualifying event, those nondisabled family members will also be entitled to this 11-month disability extension. If a child is born to or adopted (or placed for adoption) by you while you are continuing coverage and the child is determined to be disabled within the first 60 days of Continuation Coverage, the child and all family members with Continuation Coverage arising from the same qualifying event may be eligible for a total of up to 29 months of Continuation Coverage.

UNIFORMED SERVICES. Pursuant to the Veterans Benefits Improvement Act 2004 (VBIA)**,** Members of the Uniformed Services and their families are entitled to health coverage under TRICARE, the military health program. If a Covered Employee takes a leave of absence to perform services in

the Uniformed Services that is expected to last 31 days or more (as addressed in the Uniformed Services Employment and Reemployment Act (USERRA)), employers must offer employees called to active service the right to continue their employer-provided health coverage for themselves and their dependents for a period of up to 24 months.

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD. In all cases, Continuation Coverage will end for any of the following reasons:

1. Employer no longer provides group health coverage for any of its Employees;
2. Appropriate payment for Continuation Coverage is not made timely;
3. After the date of the COBRA election, the Employee or Dependent becomes covered under another group health plan;
4. After the date of the COBRA election, the Employee or Dependent becomes entitled to Medicare;
5. The Employee and/or Dependents previously extended continuation coverage beyond 18 months due to a Social Security disability, and a final determination has been made that the Qualified Beneficiary is no longer disabled;
6. A Qualified Beneficiary notifies the Employer he wishes to cancel COBRA Continuation Coverage; or
7. Any other event that would cause a Covered Person who is not on Continuation Coverage to lose Coverage under the HPP.

Written health evidence is not required to elect Continuation Coverage.

PAYING FOR CONTINUATION COVERAGE. Initial payment for Continuation Coverage must be made within 45 days from the date of Continuation Coverage election. This initial payment must pay for all months of coverage from the date of the qualifying event up to and including the month in which the payment is made. Continuation Coverage will not become effective until the full and correct initial payment is made and received. Subsequent payments are due on the first day of each month of Coverage. Premiums are delinquent if not paid by the end of the month following the due date, in which event Continuation Coverage will cease, without notice, retroactive to the first day of the month for which payment has not been made. A check that is dishonored for any reason will not be considered payment.

COST OF CONTINUATION COVERAGE. Qualified Beneficiaries must pay the entire cost of Continuation Coverage, including an additional 2% charge to cover administrative expenses. Required contribution for any part of the additional 11 months of Continuation Coverage due to disability may be increased up to 150% of the applicable premium if the disabled Qualified Beneficiary elects the extension. If only non-disabled Qualified Beneficiaries elect the extension, the applicable premium will remain at the 102% rate.

COBRA CONTINUATION COVERAGE (Continued)

NOTIFICATION OF ADDRESS CHANGE. To ensure all Covered Persons receive information properly and efficiently, it is important that you notify HealthSmart at the address listed below of any address change for you or your Dependent as soon as possible. Failure on your part to do so may result in delayed COBRA notifications or the loss of Continuation Coverage options.

HealthSmart
PO Box 91607
Lubbock, TX 79490-1607

Once Coverage under COBRA terminates, no other Coverage is available under this or any other plan offered by The County of Volusia.

PLAN INFORMATION

Name of Plan:	County of Volusia Health Partnership Plan
Name and Address of the HPP Administrator:	County of Volusia Personnel Division 230 N. Woodland Blvd., Suite 262 DeLand, FL 32720
Employer I.D. Number (EIN):	59-6000885
Plan Number:	2081
Plan Year:	January 1 to December 31
Effective Date:	October 1, 1973
Revised Effective Date:	January 1, 2016
Type of Plan:	Self-Funded Group Health Benefit Plan
Type of Participants:	All regular full-time, regular part-time Employees in regularly established positions; Retiree's, and COBRA participants.
Claims Administrator:	HealthSmart PO Box 91607 Lubbock, TX 79490-1607
Method of Funding Benefits:	Benefits are self-funded from contributions from the Employer and Employees.
Self-Funded Disclosure:	The health Coverage described in this Summary Plan Description is provided under a self-funded health Plan. Single employer self-funded plans are not regulated by the Florida Department of Insurance. The payment of claims is completely dependent upon the financial solvency of your Employer, and no guaranty fund exists to cover claims a bankrupt or insolvent employer cannot pay.
Termination or Amendment:	The County of Volusia intends to maintain This Plan indefinitely. However, the County Manager reserves the right to terminate, suspend, discontinue, or amend This Plan at any time. You will be notified in advance of any changes affecting your Coverage under This Plan.

DEFINITIONS

This section defines some of the specific terms used in This Plan. The following definitions should not be interpreted to extend Coverage and are defined for reference only. Not all of the definitions may apply to This Plan.

Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine unless the context clearly indicates the contrary.

Accident means an unforeseen and unavoidable event resulting in an Injury which is not due to any fault of the Covered Member.

Accidental Injury means a bodily Injury sustained Accidentally, and independently of all other causes by an outside traumatic event or due to exposure to the elements. The term does not include Injury which arises out of or in the course of any employment, or occupation for compensation, or profit. The term also does not include chewing injuries.

Affordable Care Act. The patient Protection and Affordable Care Act (H.R. 3590) was signed into law on March 23, 2010. The companion bill, the Healthcare and Education Reconciliation Act (H.R. 4872), as signed into law on March 30, 2010. Together, these two bills constitute what is referred to as the "Affordable Care Act" or ACA."

Alcohol Abuse Treatment Facility - See Substance Abuse Treatment Facility.

Alcoholism - See Substance Abuse.

Ambulatory Surgical Center - See Freestanding Surgical Unit.

Amendment means a formal document signed by the representatives of This Plan. The Amendment changes the provisions of This Plan and applies to all Covered Persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.

Ancillary means supplemental or secondary services provided in association with a primary service. These services are not usually selected by the member. For example, an anesthesiologist's services are supplemental or ancillary to a surgeon's services when surgical services are being provided. Ancillary services include, but are not limited to, anesthesiologists, radiologists and pathologists.

Anesthesia means the administration of an anesthetic agent by a Physician, Dentist, anesthetist, anesthesiologist, or Registered Nurse when rendered in connection with a covered Surgical, or Dental Procedure.

Annual Open Enrollment Period means the only period of time in which an Employee can enroll for Coverage, or add Dependent Coverage, except for valid Status Changes. Open Enrollment is usually the month of November.

Average Semi-Private Room Rate means the rate that is charged by the Hospital for confinement in most of its semi-private rooms.

Behavioral Health Services means the treatment of Substance Abuse, or a Mental/Nervous Disorder.

Birthing Center means a public or private facility, which meets the free standing Birthing Center requirements of the State Department of Health in the state where the Covered Member receives the

services. A Birthing Center does not mean private offices or clinics of Physicians, or a Hospital, or any part of a Hospital which has been designated as a Birthing Center.

Chiropractic Services (Spinal Manipulation) means the detection and correction, by manual manipulation (by use of hands) of the spine to correct a subluxation. Hand held devices may be used.

Claims Administrator is HealthSmart, PO Box 91607, Lubbock, TX 79490-1607.

COBRA Beneficiary means any Covered Member who is continuing participation under This Plan under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and its Amendments.

Complications of Pregnancy means conditions distinct from, but caused, or affected by Pregnancy. As applied to any Covered Member, the word "Illness" includes Complications of Pregnancy. Complications of Pregnancy include: acute nephritis, or nephrosis; cardiac decompensation; missed abortion, or similar conditions as severe as these. Complications of Pregnancy also include a non-elective cesarean section, an ectopic Pregnancy which is terminated, and spontaneous termination of Pregnancy which occurs during a period of gestation when a live birth is not possible, and pernicious vomiting (hyperemesis gravidarum), and toxemia with convulsions (eclampsia of Pregnancy).

Complications of Pregnancy **do not** include: false labor, occasional spotting, doctor prescribed rest; morning Sickness, or similar conditions which, although associated with the management of a difficult Pregnancy, are not medically classified as distinct Complications of Pregnancy.

Continuation Coverage means the Coverage provided under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and its Amendments.

Convalescent Care Facility - see Skilled Nursing Facility.

Co-Pay or **Co-Payment** means the amount payable by the Covered Person at the time of service for certain Covered Services.

Cosmetic Surgery means a procedure performed primarily to preserve, or improve appearance rather than to restore the anatomy, and/or functions of the body which are lost, or impaired due to an Illness, or Injury.

Coverage means any Coverages provided herein.

Covered Employee; Covered Dependent; Covered Person; Covered Member means an eligible participant whose Coverage became effective and has not terminated, including those eligible participants who elected to continue Coverage through the COBRA Continuation Coverage provision.

Custodial Care means care which is designed essentially to help a person in the activities of daily living, and which does not require the continuous attention of trained medical, or paramedical personnel. Such care may involve preparation of special diets, supervision over medication that can be self-administered, and assistance in getting in, or out of bed, walking, bathing, dressing, eating, and using the toilet.

Deductible means the amount you pay before certain benefits are payable from This Plan.

DEFINITIONS (Continued)

Dentist means any dental, or medical Practitioner This Plan is required by law to recognize who is properly licensed, or certified under the laws of the state where he practices and who provides services which are within the scope of his license, or certificate and covered by This Plan.

Dependent means the Covered Employee's spouse and children.

The term "***spouse***" means the legally recognized marital partner, excluding the domestic partner, of a Covered Employee. The term shall exclude such spouse who has divorced the Employee, or who is legally separated from the Employee.

The term "***children***" means natural children, step-children, foster children, or children who have been placed under legal guardianship and legally adopted children from birth to the end of the calendar year in which the child reaches the age of 26 (whether married or unmarried). This applies to any children regardless of marital status, full-time student status, level of support from employee/parent, or residence.

The Plan may choose to not extend coverage for adult children who are eligible for coverage under another employer-sponsored group health plan (other than another parent's plan), but only for plan years beginning before January 1, 2016.

The term "***children***" also means pre-adopted children (i.e., children placed with a Covered Employee in anticipation of adoption.) Such children will be provided Coverage under the same terms and conditions that apply to Dependents who are a Covered Employee's natural children, irrespective of whether the adoption has become final, and is enrolled in a timely manner as stated within.

The term "***children***" also means a Covered Member's child who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to Coverage under This Plan as an "alternate recipient." The HPP Administrator will communicate the procedures which have been established to determine whether a Medical Child Support Order is qualified under ERISA Sec. 609, and within a reasonable time after receiving an order will determine whether or not the order is qualified, and whether or not the child has been determined to be an "alternate recipient." The Covered Employee and each child who is the subject of the order will be notified of the determination. Such children may designate a representative to receive copies of all such notices.

A child determined to be an **"alternate recipient"** will be provided Coverage under the same terms and conditions that apply to Dependents who are a Covered Employee's natural children and is enrolled in a timely manner as stated within.

All children are eligible for Coverage until the end of the calendar year in which the child reaches the age of 26. However a child will remain a Dependent until the end of the calendar year in which the child reaches the age of 30, even after leaving college and home, so long as the young adult meets the following conditions:

- Must either live in Florida or be a full-time or part-time student whose parent resides in Florida;
- Must not be married;
- Must not have a dependent of his or her own;
- Must not be covered by another health plan or policy (group or individual) or by Medicare; and
- If the child was covered under the parent's health insurance policy up to the age of 26, and that coverage was subsequently terminated, the child must have been continuously covered by other health insurance without a gap in coverage of more than 63 days in order to re-enroll in the parent's health insurance policy.

Dependent children from age 26 to 30 will incur additional cost for the coverage; see your Benefits Department for details.

DEFINITIONS (Continued)

If the employee fails to notify the HPP Administrator, in writing within 60 days, of a Dependent's change in eligibility status, the Dependent shall lose the right of Continuation of Coverage under COBRA. (See the COBRA section of this book for further details.)

Special Exception for Medical Necessity (Michelle's Law): Notwithstanding the foregoing a covered Employee's unmarried child will not immediately lose eligibility to participate in the Plan if such child loses his or her required student status as a result of a change in enrollment (included a leave of absence) that (i) is medically necessary and (ii) commences while the child is suffering from a serious illness or injury. This special exception for medical necessity will delay termination of coverage until the earlier of one year from the first day of the medically necessary leave of absence or the date that the Dependent would otherwise lose coverage under the Plan for reasons other than student status (e.g. age limitations), unless the child regains full-time student status prior to such termination date.

The term ***Dependent*** also includes an Employee's unmarried child while the child is Physically, or Mentally Handicapped and is incapable of earning his own living, and who is actually dependent on either parent for a majority of his maintenance and support, and who is a Covered Member on the date immediately preceding the date his health Coverage would have terminated due to age. Proof of incapacity must be submitted to the HPP Administrator within 31-days of the date his health Coverage would have terminated due to age.

In the event both parents of an eligible Dependent child are Covered Members, then for the purposes of this Coverage, such child is considered as a Dependent of either parent, but not both parents.

No eligible person can be a Covered Employee, and a Covered Dependent at the same time. No person can be covered as a Dependent of more than one Employee.

Diagnostic Charges means the charges for x-rays, or laboratory examinations made or ordered by a Physician in order to detect a medical condition.

Disability - A person is totally disabled if prevented by Illness, or Injury from engaging in the normal duties of the occupation for 36-months, and thereafter unable to perform the duties of any occupation for which they may become qualified based on education, training, or experience. Disability determination will be made by the current Disability insurance carrier for the Employer.

Drug Abuse or Dependency - See Substance Abuse.

Durable Medical Equipment means equipment able to withstand repeated use for the therapeutic treatment of an active Illness, or Injury. Such equipment will not be covered under This Plan if it could be useful to a person in the absence of an Illness, or Injury and could be purchased without a Physician's Prescription.

Elective Hospital Admission means any non-emergency Hospital admission which may be scheduled at the patient's convenience without jeopardizing the patient's life, or causing serious impairment.

Elective Surgical Procedure means any non-emergency Surgical Procedure which may be scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment.

Eligible Charges; Eligible Expenses; Covered Expenses; Covered Charges; Covered Service means a medical treatment, or procedure given by, or under the direction of, a licensed Physician, or Practitioner of an approved type usually provided for the condition being treated and for which Coverage is provided under This Plan.

Emergency means an Illness, and/or Injury which occurs suddenly and unexpectedly, requiring immediate medical care and use of the most accessible facility equipped to furnish care to prevent the death, or serious impairment of the Covered Member.

DEFINITIONS (Continued)

Such conditions include, but are not limited to, suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsions, emergency medical care rendered to Accident cases, and other potentially life-threatening conditions.

Employee means a person who is directly employed in the regular business of and compensated for services by the Employer or any subsidiary or affiliate, and who actively expends time and energy in the service of the Employer at the Employer's usual place of business, or some other location which is usual for the Employee's particular duties, other than the Employee's home.

Employer means County of Volusia.

Experimental or Investigational Treatment means a treatment, procedure, service, device or drug (treatment) that has not been approved by the US Food & Drug Administration at the time the treatment is provided or the treatment is in Phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its safety, its efficacy, or its toxicity as compared to the standard means of treatment or diagnosis, except as required by state or federal statutes or laws.

In determining whether benefits should be excluded, the prevailing criteria for consideration will be whether the service is recognized as standard medical care for the condition, disease, illness or injury being treated.

Extended Care Facility - see Skilled Nursing Facility.

Family Status Change or Status Change means a life event which qualifies an Employee to make a change in his Coverage, outside of the Annual Enrollment Period. Below is a list of qualifying events:

1. The marriage, divorce, or legal separation (where legally recognized) of an Employee;
2. The death of the Employee's Spouse, or a Dependent;
3. The birth, or adoption of a child of the Employee;
4. The termination, or commencement of employment of Employee's Spouse;
5. The switching from part-time to full-time employment status, or from full-time to part-time status by the Employee, or the Employee's Spouse;
6. The taking of an unpaid Leave of Absence by the Employee, or Employee's Spouse;
7. A significant change occurs in the health coverage of the Employee, or Spouse attributable to the Spouse's employment; or
8. The loss of coverage related to Medicaid or SCHIP (see page 20).

Federal Food Drug Administration (FDA) The original U.S. Federal Food and Drugs Act of 1906 brought drug regulation under federal law. That Act prohibited the sale of adulterated or misbranded drugs, but did not require that drugs be approved by FDA. In 1938, Congress required that new drugs be approved for safety. In 1962, Congress amended the 1938 law to require manufacturers to show that their drug products were effective, as well as safe. As a result, all drugs approved between 1938 and 1962 had to be reviewed again for effectiveness. To be consistent with current regulations and to ensure that all drugs have been shown to be safe and effective, all new drugs are required to have an approved application for continued marketing.

Freestanding Surgical Unit means a public or private facility, licensed and operated according to the law, which does not provide services or accommodations for the patient to stay overnight. The facility must have an organized medical staff of Physicians; maintain permanent facilities equipped and operated primarily for the purpose of performing Surgical Procedures; and supply registered professional nursing services whenever a patient is in the facility. The facility may also be referred to as an Outpatient Surgical Facility, or Ambulatory Surgical Center.
The term does not include a facility for the primary purpose of performing terminations of Pregnancy, an office maintained by a Physician for the practice of medicine, or an office maintained for the practice of dentistry.

DEFINITIONS (Continued)

Genetic Information Nondiscrimination Act (GINA) – See page 15.

Home Health Services. The HPP will pay up to one visit per day, as shown in the Summary of Medical Benefits. Four (4) hours of service provided by a Nurse, therapist or a home health aid is considered to be one Home Health Care visit. Payment for these services and supplies is limited to the amount that the HPP would have paid if the Covered Person had been confined in the Hospital as a registered bed patient.

Home Health Care services are as follows:

- part-time or intermittent nursing care provided in the patient's home by registered graduate nurses, licensed practical nurses or licensed vocational nurses;
- nutrition counseling;
- medical social services;
- medical supplies provided to the patient by a member of the home health care team;
- prescription drugs provided to the patient by a member of the home health care team;
- laboratory examinations;
- physical, respiratory, inhalation, occupation or speech therapy provided in the patient's home by physical, occupation or speech therapists; and
- home health aide services in the patient's home by home health aides.

No amount will be payable for Home Health Care Covered Expenses unless the following conditions are met:

- Continued confinement in a Hospital or Skilled Nursing Facility would have been required if Home Health Care had not been available.

- The Care at home is Medically Necessary and is not primarily for Custodial Care.

- The treatment at home is for the same Illness or related condition which made the Hospital or Skilled Nursing Facility confinement necessary.

- A Doctor must have given a written order for Home Health Care Services. This order must be renewed every 30 days.

Hospice Care means a program approved by the attending Physician for care rendered in a Hospice Facility, a Hospital, or in the home to a Terminally Ill Covered Member with a medical prognosis that life expectancy is 6-months or less.

Hospice Facility means a public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive, and other related care for a Covered Member diagnosed as Terminally Ill with a medical prognosis that life expectancy is 6-months or less.

Hospital means an institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, if it: (1) provides Room and Board and nursing care for its patients; (2) has a staff with one or more Physicians available at all times; (3) provides 24-hour registered nursing service; (4) maintains on its premises all the facilities needed for the diagnosis and medical care and treatment of Sickness or Injury; and (5) provides organized facilities for major Surgery. This term does not include an institution, or that part of an institution, which is, other than by coincidence, used for: (1) rest care; (2) convalescent care; (3) care of the aged; or (4) Custodial Care.

Illness means any bodily Sickness, disease, or disorder; Pregnancy; Complications of Pregnancy; or Mental and Nervous Disorders.

DEFINITIONS (Continued)

Injury means a condition which results independently of an Illness and all other causes and is a result of an externally violent force or Accident. In regard to Dental benefits, it means all damage done to a Covered Member's mouth due to an Accident, and all complications resulting from that damage. The term does not include damage to teeth, appliances or prosthetic devices which results from chewing or biting food or other substances.

Inpatient means a person who is confined in an approved facility during the period when he is charged for Room and Board.

Intensive Care Unit means a section, ward, or wing within a Hospital which is operated exclusively for critically ill patients and provides special supplies, equipment, constant observation and care by registered graduate Nurses, or other highly trained personnel. This excludes, however, any Hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

The Joint Commission means a commission formerly The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that operates accreditation programs to subscriber hospitals and other health care organizations. The Joint Commission accreditation has become a condition of licensure and the receipt of Medicaid reimbursement for a majority of state governments.

Leave of Absence means a period of time, of stated duration, during which the Employee does not work but after which time the Employee is expected to return to active work.

Lifetime means the period of time a Covered Member is a participant in This Plan, whether in one period of time or in separate periods of time.

Medical Emergency - see Emergency.

Medically Necessary (Medical Necessity) means the care and treatment of a Covered Member must meet all of the following conditions: (a) the care and treatment is appropriate given the symptoms and is consistent with the diagnosis (appropriate means that the type, level and length of service and setting are needed to provide safe and adequate care and treatment); (b) the service or supply required for the diagnosis or treatment of an active Illness or Injury is rendered by or under the direct supervision of the attending Physician; (c) the care and treatment is rendered in accordance with generally accepted medical standards; (d) the treatment must not be generally regarded as experimental; (e) the treatment must have been proven safe and effective; (f) the treatment is consistent with current acceptable medical practices and sufficient information must be available for the success rate or risk involved; (g) the treatment is specifically allowed by the licensing statutes which apply to the provider who renders the service; and (h) treatment must not be specifically excluded under the terms of This Plan. The fact that a service is prescribed by a Physician does not necessarily mean that the service is Medically Necessary.

Medicare means Title XVIII (Health Insurance for the aged) of the United States Social Security Act as amended.

Mental/Nervous Disorder (or Illness) means a mental, or emotional disease, or disorder of any kind, including any neurosis, psychoneurosis, psychopathy, psychosis, or personality disorder which requires regular care by a Physician.

Mental/Nervous Treatment Facility means a public or private facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation, and effective treatment of Mental/Nervous Disorders; infirmary-level medical services; supervision by a staff of Physicians; and skilled nursing care by Licensed Practical Nurses who are directed by a full-time R.N. The facility must also prepare and maintain a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs.

DEFINITIONS (Continued)

Michelle's Law – See page 66.

Network Providers mean a participating Physician, Hospital, Qualified Practioner, or healthcare facility that has an in force agreement to provide healthcare services for Participants under This Plan.

Newborn Well Baby Care means the charges made by a Hospital for Nursery care, the attending pediatrician's charges for the care of a newborn child, and the Physician's charge for circumcision.

Non-Network Provider means a Physician, Hospital, Skilled Nursing Facility, Home Health Care Agency, any other duly licensed institution, or health Practitioner who is not under contract with the Preferred Provider Network.

Nurse means a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), or a Licensed Vocational Nurse (L.V.N.).

Nurse Midwife means a Registered Nurse who is certified as a Nurse Midwife by the American County of Nurse-Midwives, and who is authorized to practice as a Nurse Midwife under the state regulations.

Occupational Therapy means a program of self-care designed to restore, develop, and maintain a patient's ability to perform functional daily tasks in order to achieve maximum independence.

Orthodontic Treatment means the movement of one or more teeth by the use of active appliances. It includes diagnostic services; the Treatment Plan; the fitting, making and placement of an Active Appliance; and all related office visits, including post-treatment stabilization.

Out-of-Network Provider means any Physician, Hospital, Qualified Practitioner, or other healthcare facility that does not have an in-force agreement to provide health care services for Participants under This Plan is deemed to be non-participating and outside the scope of Network Providers.

Outpatient means a person who receives care for an Illness, or an Injury but who is not confined as an Inpatient and is not charged for Room and Board.

Outpatient Surgical Facility - See Freestanding Surgical Unit.

Personal Care Physician (PCP) means a doctor in family practice, internal medicine, gynecology, or pediatrics.

Pharmacist means a person who is licensed to prepare, compound, and dispense medication and who is practicing within the scope of his or her license.

Pharmacy means a licensed establishment where Prescription medications are dispensed by a Pharmacist.

Physical Therapy means a program of care, including exercises and movements to maximize the patient's motor skills, provided by a Registered Physical Therapist, or Licensed Massage Therapist, designed to return a patient to the highest level of motor functioning possible.

Physically or Mentally Handicapped means the inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy, or other neurological disorder and diagnosed by a Physician as a permanent and continuing condition.

Physician means a person acting within the scope of his/her license and who is legally entitled to practice medicine in all its branches under the laws of the state or jurisdiction where the services are rendered. The term includes, but is not limited to, those holding the degree of Doctor of Medicine (M.D.), Doctor of

DEFINITIONS (Continued)

Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), or a clinical psychologist who has a Ph.D. in Psychology.

Plan Administrator means the person or organization responsible for the day-to-day functions and management of This Plan. The HPP Administrator may employ persons or firms to process claims and perform other Plan-connected services.

The HPP Administrator for This Plan is County of Volusia, 230 N. Woodland Blvd., Ste. 262, DeLand, FL 32720.

Plan; This Plan whenever used herein without qualification will mean the HPP of benefits as contained in this Summary Plan Description and in any agreements, schedules and Amendments endorsed by the Employer.

Practitioner means a person acting within the scope of applicable state licensure/certification requirements and performing a service for which benefits are provided under the HPP.

Preferred Provider means a Physician, Hospital, Skilled Nursing Facility, Home Health Care Agency, any other duly licensed institution, or health Practitioner under contract with the Preferred Provider Network.

Preferred Provider Network (PPN) means the group of Physicians, Hospitals and other health care providers who have an agreement with your Employer to provide services through a PPN (Preferred Provider Network) in order to provide quality care in the most cost effective way.

Pregnancy means Pregnancy and the resulting childbirth, therapeutic abortion, or miscarriage. It does not include any Complications of Pregnancy.

Premature Birth means a birth occurring at 37-weeks, or less before full term. It also includes congenital anomalies, or any Injury or Illness existing at birth including any complications from these conditions.

Prescription means a direct order for the preparation and use of a drug, medicine or medication. This order may be given verbally or in writing by a Physician to a Pharmacist for the benefit of and use by a Covered Member. The drug, medicine or medication must be obtainable only by Prescription. The Prescription must include the name and address of the Covered Member for whom the Prescription is intended; the type and quantity of the drug, medicine or medication prescribed; and the directions for its use; the date the Prescription was prescribed; and the name, address and DEA number of the prescribing Physician.

Psychiatric Disorder means neurosis, psychoneurosis, psychopathy or psychosis.

Retiree means a former Employee who is eligible to receive benefits under the Florida State Retirement System or the Optional Retirement Plan.

Room and Board Charges means all charges made by a Hospital or a Skilled Nursing Facility on its own behalf for: (1) room and meals; and (2) all general nursing services required and provided to all individuals registered on an Inpatient basis. These Room and Board Charges must be made at a daily or weekly rate that is based on the type of room occupied.

Service Area means the geographic area within which the Preferred Provider Network's Covered Services are available.

Sickness means Illness or disease. It includes Pregnancy and the resulting childbirth, miscarriage, therapeutic abortion, or Complications of Pregnancy.

DEFINITIONS (Continued)

Skilled Nursing Facility means a public or private facility, licensed and operated according to the law, which maintains permanent and full-time facilities to mainly provide Inpatient care and treatment for persons who are convalescing from Injury or Sickness; and has a registered Nurse or Physician on full-time duty in charge of patient care; has at least one Registered Nurse or Licensed Practical Nurse on duty at all times; maintains a daily medical record for each patient; and has transfer arrangements with a Hospital and a utilization review plan in effect.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the convalescent stage of their Illness or Injury, and is not, other than by coincidence, a rest home for Custodial Care or for the aged.

Specialist means a health care provider who has advanced education and training in one clinical area of practice and limits his practice to a particular branch of medicine.

Speech Therapy means a program of care to improve the patient's motor-speech skill, expressive and receptive language skills, and writing and reading skills.

State Children's Health Insurance Program (SCHIP) – See page 20.

Status Change or Family Status Change means a life event which qualifies an Employee to make a change in his Coverage, outside of the Annual Enrollment Period. Below is a list of qualifying events:

1. The marriage, divorce, or legal separation (where legally recognized) of an Employee;
2. The death of the Employee's Spouse, or a Dependent;
3. The birth, or adoption of a child of the Employee;
4. The termination, or commencement of employment of Employee's Spouse;
5. The switching from part-time to full-time employment status, or from full-time to part-time status by the Employee, or the Employee's Spouse;
6. The taking of an unpaid Leave of Absence by the Employee, or Employee's Spouse; or
7. A significant change occurs in the health coverage of the Employee, or Spouse attributable to the Spouse's employment.
8. The loss of coverage related to Medicaid or SCHIP (see page 20).

Subluxation means an incomplete dislocation off center, misalignment, fixation or abnormal spacing of the vertebrae anatomically.

Substance Abuse means Alcoholism, the regular excessive compulsive drinking of alcohol. It is characterized by continuous or periodic impaired control over drinking, preoccupation with alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial.

Substance Abuse also means Drug Dependency, being physically or emotionally dependent on drugs, narcotics or any other addictive substance that results in a primary chronic disorder with genetic, psychosocial, and environmental factors influencing its development and manifestations and affecting, to a debilitating degree, physical health and/or personal or social functioning.

Substance Abuse does not include dependence on tobacco and ordinary caffeine-containing drinks.

Substance Abuse Treatment Facility means a public or private facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation, and effective treatment of Substance Abuse including Alcoholism and Drug Dependency. The facility must be supervised by a staff of Physicians and must provide skilled nursing care by licensed Nurses who are directed by a full-time R.N.

DEFINITIONS (Continued)

Surgery or Surgical Procedure means any of the following procedures (excluding oral Surgical Procedures):

1. incision, excision, or electrocauterization of any organ or body part;
2. reconstruction of any organ, or body part, or the suture repair of lacerations;
3. reduction of a fracture, or dislocation by manipulation;
4. use of endoscopic procedure to explore for, remove a stone, or other object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder, or ureter;
5. puncture for aspiration;
6. injection for contrast media testing; or
7. laser Surgery.

Same Incision means all surgeries performed using one (1) incision.

Separate Incisions means surgeries performed using two (2) or more incisions.

Operative Field means the exposed area of the body which has been scrubbed or sterilized.

Separate Operative Fields means two (2), or more separate areas of the body which have been surgically scrubbed or sterilized.

Incidental Procedure means a procedure for which an additional charge is not reasonable. These procedures include, but are not limited to, incidental appendectomy, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernia, etc.

Independent Procedure means a procedure that is performed independently and is not immediately related to other services.

A Terminally Ill Person means a Covered Person whose life expectancy is 6-months, or less as certified by a Physician.

Treatment Plan means a report of recommended treatment on a form satisfactory to This Plan which itemizes the procedures and charges required for the necessary care of the Covered Member; lists the charges for each procedure; and is accompanied by supporting x-rays and any other appropriate diagnostic materials required by This Plan.

Urgent Care Facility means a free standing care facility which provides medical care for minor Emergencies and urgent medical problems, but which is not located within an acute-care Hospital.

Usual and Customary, and Reasonable Charge means a charge which must be within the range most frequently used in the same or similar medical Service Area for the same service or procedure, with consideration given to unusual circumstances involving medical complications requiring additional time, skill and experience.

For medical expenses the Usual and Customary, and Reasonable Charges are based on the amounts set forth by the Payment Systems at 50%.

This provision will not apply if a Covered Member must use the services of a Non-Network Provider because the necessary specialty is not represented in the Network. Such specialist care will be provided at Expanded Network benefit levels.

DEFINITIONS (Continued)

For facility fee expenses incurred at a Freestanding Surgical Unit, or Ambulatory Surgical Center the Usual and Customary, and Reasonable Charges are 125% of the fees allowed by Medicare.

For dental expenses under the Plan the Usual and Customary, and Reasonable Charges are based on the amounts set forth by the Payment Systems at 80%.

Walk-in-Clinic means a facility that is staffed with Personal Care Physician's that generally provide medical care on a walk-in basis and does not require scheduled appointments.

Working Day means any day Monday through Friday between the hours of 8 a.m. and 5:00 p.m. EST, excluding holidays.

PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

Group Health Plan's Designation of Entity to Act on its Behalf.

The **County of Volusia Health Partnership Plan** (the HPP) has determined that it is a Group Health Plan within the meaning of the HIPAA Privacy Rule, and the HPP designates the HPP Sponsor, **County of Volusia**, to take all actions required to be taken by the Group Health Plan in connection with the HIPAA Privacy Rule.

This Section applies to the HPP solely to the extent it provides medical and any other benefits that constitute group health plan benefits under 45 C.F.R. §160.103, and does not apply to any non-health benefits or benefits that provide or pay for the cost of excepted benefits that are listed in 42 U.S.C. §300gg 91(c)(1).

A. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

(1) The HPP will use PHI to the extent of, and in accordance with, the uses and disclosures permitted by HIPAA, including but not limited to health care treatment, payment for health care, health care operations and as required by law. The Privacy Notice will list the specific uses and disclosure of PHI that will be made by the HPP.

(2) Disclosure to the HPP Sponsor. The HPP will disclose PHI to the HPP Sponsor only upon receipt of written certification from the HPP Sponsor that:

(3) The HPP document has been amended to incorporate the provisions in this Section; and

(4) The HPP Sponsor agrees to implement the provisions in Subsection B below.

B. CONDITIONS IMPOSED ON PLAN SPONSOR. Notwithstanding any provision of the HPP to the contrary, the HPP Sponsor agrees:

(1) **Biweekly Premiums** Not to use or disclose PHI other than as permitted or required by this Section or as required by law;

(2) To ensure that any agents, including a subcontractor, to whom the HPP Sponsor provides PHI received from the HPP agree to the same restrictions and conditions that apply to the HPP Sponsor with respect to PHI received or created on behalf of the HPP and ensure that such individuals agree to implement reasonable and appropriate security measures to protect electronic PHI;

(3) Not to use or disclose an individual's PHI for employment-related purposes (including hiring, firing, promotion, assignment or scheduling) unless authorized by the Individual. Notwithstanding this paragraph (3), the HPP Sponsor may use enrollment, disenrollment and eligibility information as permitted by 45 C.F.R. Parts 160-164 to perform enrollment and disenrollment functions.

For any successful unauthorized, attempts to access, use disclose, modify or destroy electronic Protected Health Information or interfere with systems in operations in an information system containing electronic Protected Health Information, the HPP Sponsor shall report in writing any such use or disclosure to the HPP as soon as administratively possible;

(4) To provide Individuals with access to PHI in accordance with 45 C.F.R. §164.524;

(5) To make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. §164.526;

(6) To make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;

(7) To make internal practices, books and records relating to the use and disclosure of PHI received from the HPP available to the Secretary of Health and Human Services for purposes of determining the HPP's compliance with HIPAA;

If feasible, to return or destroy all PHI received from the HPP that the HPP Sponsor maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible;

To ensure adequate separation supported by reasonable and appropriate security measures is implemented between the HPP and the HPP Sponsor as required by 45 C.F.R. §164.504(f)(2)(iii) and described in this Section; and

(8) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that the HPP Sponsor creates, receives, maintains or transmits on behalf of the HPP.

C. DESIGNATED EMPLOYEES WHO MAY RECEIVE PHI. In accordance with the Privacy Rules, only certain, designated Employees who perform Plan administrative functions may be given access to PHI. Those Employees or class of Employees who have access to PHI are as follows (or their equivalents and successors within the HPP Sponsor's workforce):

(1) Benefits Department;

(2) Privacy Official;

(3) Members of the Corporate in-house legal staff who have limited access to Participant's PHI for purposes of assisting with Plan interpretation; and

(4) Members of the Payroll and Information Technology Departments who have limited access to Participant's PHI.

D. RESTRICTIONS ON EMPLOYEES WITH ACCESS TO PHI. The Employees who have access to PHI may only use and disclose PHI for Plan administration functions that the HPP Sponsor performs for the HPP, as set forth in the Privacy Notice, including but not limited to, quality assurance, claims processing, auditing, monitoring, and management of the HPP and coordination with other benefits.

E. POLICIES AND PROCEDURES. On or before the effective date of the Privacy Rules, the HPP Sponsor shall have implemented Policies and Procedures setting forth operating rules to implement the provisions hereof.

F. ORGANIZED HEALTH CARE ARRANGEMENT. It is intended that the HPP may form part of an Organized Health Care Arrangement.

G. HYBRID ENTITY DESIGNATION. The HPP Administrator intends the HPP to be a Hybrid Entity in accordance with 45 C.F.R. §164.504(b) and only those benefits that would be a covered health plan under 45 C.F.R. §160.103 (if set forth as a separate plan) will constitute the health care components of the HPP. Any benefit offered by the HPP that would not be a covered health plan under 45 C.F.R. §160.103 if providedthrough a separate plan is a non-health care component of the Hybrid Entity and is not subject to the Privacy Rules.

H. PRIVACY OFFICIAL. The HPP shall designate a Privacy Official, who will be responsible for the HPP's compliance with the privacy provisions of HIPAA. The Privacy Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Privacy Official deems necessary or advisable. In addition, and notwithstanding any provision of this Plan to the contrary, the Privacy Official shall have the authority to and be responsible for:

(1) Accepting and verifying the accuracy and completeness of any certification provided by the HPP Sponsor under this Section;

(2) Transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to the HPP Sponsor;

(3) Establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the HPP with the Privacy Rules;

(4) Establishing and overseeing proper training of the HPP, or the HPP Sponsor personnel who will have access to PHI; and

(5) Any other duty or responsibility that the Privacy Official, in his or her sole capacity, deems necessary or appropriate to comply with the Privacy Rules and the purposes of this Section.

I. SECURITY OFFICIAL. The HPP shall designate a Security Official, who will be responsible for the HPP's compliance with the security provisions of HIPAA. The Security Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Security Official deems necessary or advisable. In addition, and notwithstanding any provision of this Plan to the contrary, the Security Official shall have the authority to and be responsible for:

(1) Accepting and verifying the accuracy and completeness of any certification provided by the HPP Sponsor under this Section;

(2) Transmitting the certification to any third parties as may be necessary to permit them to disclose electronic PHI to the HPP Sponsor;

(3) Establishing and implementing policies and procedures with respect to electronic PHI that are designed to ensure compliance by the HPP with the security requirements of HIPAA;

(4) Establishing and overseeing proper training of the HPP, or Plan Sponsor personnel who will have access to electronic PHI; and

(5) Any other duty or responsibility that the Security Official, in his or her sole capacity, deems necessary or appropriate to comply with the security provisions of HIPAA and the purposes of this Section.

J. NONCOMPLIANCE. The HPP Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for personnel who do not comply with the provisions of this Section.

K. INTERPRETATION AND LIMITED APPLICABILITY. This Section serves the sole purpose of complying with the requirements of HIPAA and shall be interpreted and construed in a manner to effectuate this purpose. Neither this Section nor the duties, powers, responsibilities, and obligations listed herein shall be taken into account in determining the amount or nature of the benefits provided to any person covered under this Plan, nor shall they inure to the benefit of any third parties. To the extent that any of the provisions of this Section are no longer required by HIPAA, they shall be deemed deleted and shall have no further force or effect.

PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION (Continued)

L. SERVICES PERFORMED FOR THE HPP SPONSOR. Notwithstanding any other provision of this Plan to the contrary, all services performed by a business associate for the HPP in accordance with the applicable service agreement shall be deemed to be performed on behalf of the HPP and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. parts 160 through 164, except services that relate to eligibility and enrollment in the HPP. If a business associate of the HPP performs any services that relate to eligibility and enrollment to the HPP, these services shall be deemed to be performed on behalf of the HPP Sponsor in its capacity as Plan sponsor and not on behalf of the HPP.

M. DEFINITIONS. As used in this Section, each of the following capitalized terms shall have the respective meaning given below:

- **HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.
- **Individual** means the person who is the subject of the heath information created, received or maintained by the HPP or the HPP Sponsor.
- **Organized Health Care Arrangement** means the relationship of separate legal entities as defined in 45 C.F.R. §160.103.
- **Privacy Notice** means the notice of the HPP's privacy practices distributed to Plan participants in accordance with 45 C.F.R. §164.520, as amended from time to time.
- **Privacy Rules** means the privacy provisions of HIPAA and the regulations in 45 C.F.R. Parts 160 and 164.
- **Protected Health Information (PHI)** means individually identifiable health information as defined in 4
- **C.F.R. §160.103.**
- **Security Incident** means an incident as defined in 45 C.F.R. §164.304.

2016 ANNUAL HEALTH INSURANCE NOTICES

Newborns' Act Disclosure
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WHCRA Notice
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Women's Health & Cancer Rights Protections
The Women's Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans and health insurance issuers that provide coverage for medical and surgical benefits with respect to mastectomies must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymph edema).

Medicaid and the Children's Health Insurance Program (CHIP)
If you and your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think your or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS now or www.insurekidsnow.giv to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. You must request coverage within 60 days of being determined eligible for premium assistance.

Summary of Benefits and Coverage (SBC):
Health insurance issuers and group health plans are required to provide benefit eligible employees with an easy-to-understand summary about a health plan's benefits and coverage. The new regulation is designed to help you better understand and evaluate your health insurance choices.

All insurance companies and group health plans must use the same standard SBC form to help you compare health plans. The SBC form also includes details, called "coverage examples," which are comparison tools that allow you to see what the plan would generally cover in two common medical situations. You have the right to receive the SBC when shopping for or enrolling in coverage or if you request a copy from your issuer or group

health plan. You may also request a copy of the glossary of terms from your health insurance company or group health plan.

Flexible Spending Account (FSA) – Change in Annual Limit:
Beginning with the new plan year starting on 9/1/13, annual contributions to FSA medical will be limited to $2,500 each year.

NOTICE REQUIREMENT UNDER MICHELLE'S LAW
Under Michelle's Law, a group health plan cannot terminate a child's coverage for loss of full-time student status if the change in student status is due to a "medically necessary leave of absence."The plan may be required to allow such a

Child to remain covered as an employee's dependent for up to a year after the leave of absence begins. The law also includes a notice requirement that is not strictly annual but is likely to work out to be a required item for many employers' annual enrollment packets. Whenever an employer provides a notice that certification of student status is required to maintain certain dependents' eligibility under the plan, that notice must include a description of the continued coverage that is available under "Michelle's Law" in language that is understandable to the typical plan participant.

Michelle's Law applies to plan years beginning on or after October 9, 2009 and to medically necessary leaves of absence that begin during those plan years. The law is effective January 1, 2010 for calendar year plans.

Important Notice from the County of Volusia About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **County of Volusia** and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. HealthSmart has determined that the prescription drug coverage offered by the County of Volusia Employee Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current County of Volusia coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current County of Volusia coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with County of Volusia and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through County of Volusia changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage: Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help, Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 10/15/15
Name of Entity/ Sender: County of Volusia
Contact: Personnel Division
Address: 230 N Woodland Blvd, Suite 262, DeLand, FL 32720
Phone Number: 386-736-5951

CMS Form 10182-CC
OMB 0938-0990
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

PO Box 91607, Lubbock, TX 79490-1607
Phone + 1 (855)-224-5173– Fax + 1(863) 291-5010

Authorization for Release of Information

I authorize the use and disclosure of my protected health information as described below.

Member's Name: _____ Date of Birth: ___/___/_____

Address: _____ Telephone#: _____
(Street, City, State, and Zip Code)

Employee/Subscriber Name: _____ Employee/Subscriber ID: _____

Group Health Plan Name: _____ Group/ID Number: _____

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that my health information may contain information created by other persons or entities including health care providers, and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, reproductive and sexually transmitted disease information. I further understand that by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.

I understand that my health plan may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I authorize the following entity to release my protected health information to the individuals listed on this form:

_____
Name of Individual(s), Provider(s), or Organization(s): For example, HealthSmart

The protected health information that may be used and disclosed is as follows:

- ☐ Claims
- ☐ Eligibility/Benefits
- ☐ Treatment Plan(s)
- ☐ Progress Reports
- ☐ Information for benefit determinations
- ☐ All
- ☐ Other (describe in detail):

PO Box 91607, Lubbock, TX 79490-1607
Phone + 1 (855) 224-5173 – Fax + 1(863) 291-5010

Date of records to be disclosed: From: _____ **To:** _____

Include information pertaining to (check any that apply and that you wish to be disclosed):
☐ Mental Health ☐ HIV/Aids ☐ Alcohol/Drug Rehabilitation ☐ STD/Reproductive Treatment

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The following Individual(s), Provider(s), or Organization(s) is authorized to receive my protected health information:

(Please list the specific names and relationship if possible)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer be protected by federal privacy regulations.

I understand that I may refuse to sign this authorization. I further understand that my group health plan will not condition enrollment in the plan or eligibility for benefits on my signing this authorization.

I understand that I may revoke this authorization at any time by sending a written notification to HealthSmart Benefit Solutions, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that was previously used or disclosed, relying on this authorization.

*** This form should be signed by the member. If the member is unable to sign a Personal Representative may sign on their behalf; if the representative has the appropriate authority.**

Name: _____ **Signature:** _____ **Date:** _____
(Print of Member/ Guardian/ Member Representative)

Name: _____ **Signature:** _____ **Date:** _____
(Print of Member/ Guardian/ Member Representative)

Name of Personal Representative: _____

Description of Personal Representative Authority: _____

Mail or fax completed form to:

HealthSmart
PO Box 91607
Lubbock, TX 79490-1607
Fax: (863) 291-5010

Health Partnership Plan
County of Volusia

Authorization for Use of Disclosure of Protected Health Information for Assistance Purposes

I, _____, hereby authorize Health Partnership Plan Administrator
(Print name of patient)

to use the following protected health information to assist me in my claims resolution.

Description of protected health information to be used and/or disclosed:

_____

_____

_____

_____

The purpose for the use and/or disclosure of the protected health information listed above is:

_____

_____

_____

_____

This authorization is valid from _____ to _____.

After the ending date, this authorization to use and/or disclose the protected health information above will expire.

I understand that I have the right to revoke this authorization, in writing, at any time. Such revocation must be made in writing and sent to Tom Motes, Human Resource Director, Personnel Division, (386) 736-5951; 230 N. Woodland Blvd., Suite 262, DeLand, FL 32720, or emailed to tmotes@co.volusia.fl.us.

My revocation will not be effective to the extent that the Health Partnership Plan has relied on the use of disclosure of the protected health information. However, my revocation will be effective from the date of the revocation forward.

I understand that information used or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

I acknowledge that I have signed a consent form for the Health Partnership Plan Administrator and that I am aware of the Health Partnership Plan "Notice of Privacy Practices."

I understand that I have the right to inspect or copy my protected health information to be used and/or disclosed as permitted under federal and/or state law. I understand that I have the right to refuse to sign this authorization and in so doing, this authorization will not be effective.

_____
Signature of Patient or Personal Representative/Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority