

COUNTY OF VOLUSIA

Health Partnership Plan

For Schedule of Benefits, See Pages 2, 3 & 4

Summary Plan Description

Revised Effective: January 1, 2004

Group No. 2081

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, 2004. This Plan is an amendment of the Plan 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 Plan has been amended as of 12:01 a.m., January 1, 2004, to provide benefits for expenses incurred on and after January 1, 2004, and other Plan provisions as set forth in this Summary Plan Description. Covered expenses incurred prior to January 1, 2004, will be administered in accordance with the terms of the Plan in effect through midnight, December 31, 2003. 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 Employee Health Benefits Plan. 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, Dental and Behavioral Health services. It should be noted that any claims are to be filed with United Benefits, Inc. Behavioral Health services and claims are being handled by The Allen Group (TAG) and Pharmaceutical services and claims are being handled by Walgreens Health Initiatives.

To keep your medical costs to a minimum, all Hospital admissions and other specified surgical and medical services are to be certified by Preferred Physicians Healthcare Alliance (PPHA) by calling 1-888-522-7742. All Behavioral Health Services are to be certified by The Allen Group by calling 1-800-272-7252.

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 Plan provisions, and are not meant to convey or imply that any greater or lesser benefits are payable than are covered under the Plan.

**THESE PLANS MAY CONTAIN CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES,
PRE-EXISTING CONDITION AND PENALTY PROVISIONS.
PLEASE READ THIS DOCUMENT CAREFULLY.**

TABLE OF CONTENTS

INTRODUCTION	II
YOUR BENEFITS	1-13
Schedule of Medical Benefits	2-4
Pre-certification and Authorization of Medical Care	5-6
Preventive Services	7
Preventive Care Benefit	8
Schedule of Pharmaceutical Benefits	9
Prescription Drug Program	9-10
Schedule of Dental Expense Benefits	11
Schedule of Behavioral Health Benefits	12
Pre-certification and Authorization of Behavioral Health Benefits	13
SECTION A	
Eligibility	A-1
IRS Section 125 – Flexible Benefit Plans	A-2-A-3
Employee and Dependent Enrollment	A-3
Change in Status	A-4
Special Enrollment Rules	A-4-A-5
Newborn Children	A-5
Changes in Coverage	A-5
Termination of Coverage	A-6
Leaves of Absence	A-7
Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA)	A-7
SECTION B	
General Plan Provisions	B-1-B-3
Deductibles	B-1
Co-Insurance Percentage	B-1-B-2
Out-of-Pocket Expense	B-2
Pre-Existing Conditions Limitations	B-3
Your Right to Demonstrate Creditable Coverage	B-3
Covered Medical Expenses	B-4-B-11
Medical Benefit Exclusions & Limitations	B-12-B-14
Prescription Drug Limitations and Exclusions	B-15
General Dental Provisions	B-16
Covered Dental Expenses	B-17
Dental Benefit Limitations	B-18
Dental Benefit Exclusions	B-19
SECTION C	
Your Medicare Supplement Coverage	C-1-C-2
How to File a Claim	C-3
Claim Denial and How to Appeal a Denial of Benefits	C-4
General Claim Provisions	C-5-C-6
Coordination of Benefits	C-7-C-9
Integration of Benefits with Medicare	C-8
Extension of Benefits after Plan Termination	C-10
Right of Subrogation	C-11-C-12
Continuation of Coverage (COBRA)	C-13-C-15

TABLE OF CONTENTS (Continued)

Plan Information	C-16
Definitions	C-17-C-27
Health Insurance Portability & Accountability Act Of 1996 (HIPAA) - Privacy Rule	C-28-C-36

YOUR BENEFITS

SCHEDULE OF BENEFITS

INDIVIDUAL MAXIMUM LIFETIME BENEFIT **\$1,000,000**
 (Includes all paid claims for Medical & Behavioral Health)

FERTILITY STUDIES - MAXIMUM LIFETIME 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.

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.

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
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CALENDAR YEAR DEDUCTIBLE
 (Includes Medical and Behavioral Health Expenses Only)

Individual	None	\$500	\$2,000
Family	None	\$1,500	\$6,000

OUT-OF-POCKET MAXIMUM EXPENSE
 - INCLUDES CO-PAYS & CO-INSURANCE PERCENTAGES
 (Includes Medical and Behavioral Health Expenses Only)

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 (\$200 Maximum Benefit)	\$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)	\$15	20%	40%
Specialist's Office Visit	\$25	20%	40%
Obstetrical Care Including Delivery (One-time charge)	\$100	20%	40%
Physician Inpatient Visit	\$0	20%	40%
Outpatient Surgery	\$25	20%	40%
Office Surgery - (includes, but is not limited to, joint injections, fetal stress tests, nasal endoscopies)	\$25	20%	40%
Allergy Injections	\$0	\$0	\$0

SCHEDULE OF BENEFITS

	In Network	Expanded Network	Out-of- Network
WALK-IN CLINIC			
Personal Care Physician (PCP)	\$15	20%	40%
Specialist	\$25	20%	40%
(Available Network Walk-in Facilities)			
Jena Medical Family Practice - Orange City, FL			
MediQuik Walk-in Clinic - Palm Coast, FL			
Memorial Health Center-Daytona Beach - Daytona Beach, FL			
Ormond Medical Arts - Ormond Beach, FL			
URGENT CARE/WALK-IN FACILITY	\$50	20%	40%
(Available Network Urgent Care/Walk-in Facilities)			
Halifax Medical Center-Atlantic/Urgent Care/Walk-in Facility - Daytona Beach, FL			
Halifax Medical Center-Ormond Beach/Urgent Care/Walk-in Facility			
Halifax Medical Center-Port Orange/Urgent Care/Walk-in Facility			
HOSPITAL SERVICES			
Inpatient Services - Per Admission	\$200	20%	40%
Outpatient Surgery - Per Surgery (includes 23-hour observation)	\$200	20%	40%
SPECIALTY HOSPITALS			
(by Referral Only as determined by the Pre-Certification Company)			
EMERGENCY SERVICES - PER VISIT			
Emergency Room (waived if admitted)	\$50	20%*	40%*
Ambulance Services (Volusia County EVAC Services will be paid as In-Network)	\$50	20%	40%
*Deductible will not apply			
DENTAL SURGERY (In a Dentist's office)	\$25	20%	40%
(See Teeth, Gums and Alveolar Process)			
SKILLED NURSING FACILITY - PER ADMISSION	\$50	20%	40%
HOSPICE	\$0	20%	40%
OUTPATIENT LAB, X-RAY & OTHER			
DIAGNOSTIC PROCEDURES - PER VISIT			
Diagnostic X-Rays	\$10	20%	40%
CAT	\$10	20%	40%
MRI	\$10	20%	40%
Lab Tests and Services	\$10	20%	40%
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 Therapy)	\$20	20%	40%
HOME HEALTH	\$0	20%	40%
DURABLE MEDICAL EQUIPMENT/ORTHOPEDIC DEVICES (does not include diabetic supplies)	\$10	20%	40%
MEDICAL SUPPLIES (for medical supplies other than diabetic supplies or DME)	\$0	20%	40%
PROSTHETIC DEVICES - PER DEVICE	\$100	20%	40%
Rx	Retail	Mail	
Generic	\$10	\$20	50%
Preferred Brand	\$25	\$50	50%
Non Preferred Brand	\$40	\$80	50%

PRE-CERTIFICATION AND AUTHORIZATION OF MEDICAL CARE

Preferred Physicians Healthcare Alliance (PPHA) 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 a possible denial of benefits or 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:

**Preferred Physicians Healthcare Alliance (PPHA)
(888)- 522-7742**

--- All Inpatient Care; and

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

- Adenoidectomy
- Back Surgery
- Colonoscopy – under age 50
- Durable Medical Equipment – **over \$250**
- Endocrinology Services pertaining to Infertility/Reproduction
- Home Health Care
- Hyperbaric Oxygen Treatments
- Interventional Pain Services
- Mammoplasty; 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
- Varicose Vein Excision and Ligation

Scheduled Inpatient care should be pre-certified 7 days prior to admission. Emergency Inpatient admissions must be reported to Preferred Physicians Healthcare Alliance (PPHA) within 24-hours or the next Working Day after an emergency admission.

PRE-CERTIFICATION AND AUTHORIZATION OF MEDICAL CARE (Continued)

Outpatient surgeries or other medical services must be pre-certified 7 days or as early as possible prior to the delivery of medical services.

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.

Preferred Physicians Healthcare Alliance (PPHA) assesses the need for alternative care and, when necessary, will refer the case for Medical Case Management.

PPHA 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 Plan Administrator, 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 Plan Administrator.

In conjunction with these services, the Plan 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.

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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.

The Plan has the absolute authority to waive the normal provisions of the Plan if PPHA 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 Plan 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 Plan.

THIS PAGE CONTAINS PENALTY PROVISIONS.

PREVENTIVE SERVICES

This Plan may cover Annual Physical Examinations for Covered Employees and Covered Spouses only. Well Woman Services are provided for Covered Employees, Covered Spouses and Covered Dependent Children age 18 and over.

Preventive Services are not subject to the Calendar Year Deductible.

Annual Physical Examinations

One Annual Routine Physical Exam is covered each calendar year when using a Preferred Provider Physician in one of the following specialties: Family Practice, General Practice, Internal Medicine, or Gynecology.

The **\$200 Maximum** Annual Routine Physical benefit includes, and is limited to, any combination of the following services:

- Physical examination and history
- EKG
- Blood tests
- Hemocult
- Urinalysis
- Chest X-Rays
- Bone Density Study – age 45 and over
- Hearing Screening
- Sigmoidoscopy
- PSA Blood Test
- Inoculations and immunizations
- Digital prostate exam

Charges in excess of the \$200.00 maximum are the patients' responsibility and do not track towards the annual Out-of-Pocket maximum.

Well Woman Services

Covered benefits include a screening mammogram and an annual pelvic examination with pap smear. Screening mammograms are covered according to the following guidelines:

Ages 35-39
Baseline

Ages 40-49
Annual

Ages 50-64
Annual

Ages 65+
Every 2 Years

Well Child Care Services

The Plan covers certain Well Child Services provided by a Physician from the moment of birth through age sixteen.

The Covered Services for each visit to the Physician include: a history, anticipatory guidance, Physician examination, appropriate immunizations, developmental assessment, and laboratory tests in keeping with prevailing medical standards.

The Plan allows for a maximum of 18 visits.

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, 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 Plan 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 6.
6. Verify that the Physician's office codes the claim as preventive care and forwards the claim to United Benefits, Inc. 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 United Benefits, Inc. for processing. No Deductible or Co-Payment is applied.
9. Maximum dollar benefit provided under this Plan is **\$200**.
10. Well woman screenings are covered at 100%.
11. 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.

SCHEDULE OF PHARMACEUTICAL BENEFITS

	GENERIC DRUG	PREFERRED BRAND DRUG	NON PREFERRED BRAND DRUG
	<u>YOU PAY</u>	<u>YOU PAY</u>	<u>YOU PAY</u>
CALENDAR YEAR DEDUCTIBLE PAYABLE BY COVERED MEMBER:	-0-	-0-	-0-
CO-PAYMENT PAYABLE BY COVERED MEMBER: Drugs purchased from a WHP network retail Pharmacy			
Each 30-day supply	\$10	\$25	\$40
CO-PAYMENT PAYABLE BY COVERED MEMBER: Drugs purchased from WHP Mail Service Pharmacy			
31- to 90 day supply	\$20	\$50	\$80
CO-INSURANCE PERCENTAGE PAYABLE: Drugs purchased from a non-network Pharmacy			
Maximum 31-day supply	50%	50%	50%

WHP PRESCRIPTION DRUG PROGRAM

Walgreens Health Initiatives (WHP) provides the Pharmacy network for the Health Partnership Plan (HPP). WHP has over 45,000 retail pharmacies in the United States as well as a Mail Service Program for maintenance medications. For a list of WHP pharmacies in Volusia County and WHP chain pharmacies throughout the United States, please refer to the Health Partnership Plan Preferred Provider Directory.

Because WHP 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 the WHP Managed Prescription Mail Service Program. Maintenance drugs are covered for up to a 90-day supply.

Mail Service Order Forms are provided by WHP and are included with the "Retail and Mail Service Pharmacy Benefit" brochure which are available from your Benefits Office.

To utilize your mail order benefit, please use the order form provided in the "Retail and Mail Service Pharmacy Benefit" brochure, access forms on the web-site www.whphi.com or mail to the following address:

Walgreens Health Initiatives
7357 Greenbriar Parkway
Orlando, FL 32819-8917

WHP PRESCRIPTION DRUG PROGRAM (Continued)

Under emergency circumstances with approval, prescription drugs may be obtained from a non-network Pharmacy. You will be reimbursed by the Plan 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 WHP on a WHP Prescription Drug Claim Form available from your Benefits Office or WHP.

If you have questions about your Prescription drug benefit, WHP's Managed Prescription Mail Service Program, the retail Pharmacy network, or about medications, please call WHP at 800-207-2568. WHP Pharmacists are well informed about Prescription drugs and will address your questions and concerns. If you need a replacement ID Card, please call United Benefits, Inc. at 386-239-5710 or 1-800-323-4890.

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 \$40 non-preferred co-payment plus the \$25 difference between the cost of the brand and cost of the generic drugs. Your cost will be \$65.

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 \$40 totaling \$125. 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 Plan will dispense and cover the brand drug.

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. Insulin, syringes, needles, and chemical strips 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 WHP Mail Service Pharmacy.

SCHEDULE OF DENTAL EXPENSE BENEFITS

LIFETIME MAXIMUM BENEFIT FOR TYPE IV SERVICES\$1,000
 (Inclusive of Expenses for both Orthodontic and Implant Services)

CALENDAR YEAR MAXIMUM BENEFIT FOR ALL TYPE I, II, & III SERVICES.....\$1,000

CALENDAR YEAR DEDUCTIBLE	<u>You Pay at SMILE Dentist</u>	<u>You Pay at Non-Network Dentist</u>
❖ Type I		
➤ Individual	None.....	None
➤ Family.....	None.....	None
❖ Types II, III, and IV		
➤ Individual	\$50	\$50
➤ Family.....	\$150	\$150

CO-PAYMENT/CO-INSURANCE PERCENTAGE PAYABLE

❖ Type I – Preventive Services		
➤ Oral Exams and X-Rays (Adult)	\$0*	20%
➤ Two (2) Cleanings per Calendar Year including fluoride treatment for children	\$0*	20%
❖ Type II – Restorative Services		
➤ Fillings, Extractions, Periodontics, Endodontics, and Root Canals.....	20%**	20%
❖ Type III – Replacement Services		
➤ Crowns, Bridges, and Dentures	50%**	50%
❖ Type IV – Orthodontic and Implant Services		
➤ Orthodontics.....	50%**	50%
➤ Implants.....	50%**	50%

NOTE: Any Employee, or Dependent covered under This Plan will have free choice of his/her Dentist. The SMILE network of Dentists is available. Any Employee who chooses a SMILE Network Dentist will have a lower Out-of-pocket expense.

*Depending on the Dentist, a covered member may have to pay for their services at the time of their visit and then submit a claim to be reimbursed. Some Dentists may not request payment at that time and submit the claim for the covered member. Regardless of the Dentist, the covered member will pay \$0 after reimbursement.

**Percent that you pay of reduced SMILE Dentist charges

**Any amount over UCR (Usual, Customary, and Reasonable Charges as defined in Section C.)
 FOR DETAILS, REFER TO THE PLAN PROVISIONS CONTAINED ON PAGE B-1.**

SCHEDULE OF BEHAVIORAL HEALTH BENEFITS

LIFETIME MAXIMUM SUBSTANCE ABUSE BENEFITS\$25,000

CALENDAR YEAR MAXIMUM MENTAL HEALTH BENEFITS 30 days (Inpatient)

OUT-OF-POCKET MAXIMUM EXPENSE (includes Covered Medical Expenses)	<u>In - Network</u>	<u>Expanded Network</u>	<u>Out-of- Network</u>
◆ Individual Per Calendar Year	\$5,000	\$5,000	\$10,000
◆ Family Per Calendar Year	\$10,000	\$10,000	\$20,000

CO-PAYMENT/CO-INSURANCE PERCENTAGE PAYABLE BY COVERED MEMBER

◆ Inpatient	\$200	20%	40%
◆ Outpatient	\$15	20%	40%

BEHAVIORAL HEALTH EXCLUSIONS

In addition to The Medical Benefit Exclusions & Limitations, This Plan **will not** pay for, and Covered Behavioral Health Expenses **do not** include:

1. Marital or family counseling;
2. Biofeedback, hypnosis, or any form of self-care or self-help training;
3. Counseling or services for weight control.

**Free EAP Services
are provided by *The Allen Group*.**

**For more information, call
1-800-272-7252**

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 12.

PRE-CERTIFICATION AND AUTHORIZATION OF BEHAVIORAL HEALTH BENEFITS

All Inpatient and Outpatient 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 *The Allen Group* at 1-800-272-7252 to schedule a Pre-certification appointment for you and your counselor to discuss a treatment plan before any services are rendered.

Pre-certification of 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 will result in the following penalties (not to exceed Covered Charges):

**Inpatient - \$1,000 per admission;
Outpatient - \$250 per occurrence**

The Plan has the absolute authority to waive the normal provisions of the Plan if The Allen Group 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.

The Allen Group also provides free Employee Assistance Program (EAP) services 24-hours a day to all employees and their family members, as well as pre-certification and authorization of behavioral health benefits under This Plan.

EAP Services provide free short-term counseling for any problem which affects your well-being or ability to perform at work. Examples include stress, family or marital problems, substance abuse, financial or legal difficulties, or emotional problems. By using the EAP free services, you may avoid having to use costly behavioral health services altogether. Call The Allen Group at 1-800-272-7252 for complete details.

**Contact *The Allen Group* at
1-800-272-7252
24-hours a day, 7 days a week.**

THIS PAGE CONTAINS PENALTY PROVISIONS.

SECTION A

IN THIS SECTION YOU WILL FIND INFORMATION REGARDING:

Eligibility A-1

IRS Section 125 – Flexible Benefit Plans A-2-A-3

Employee and Dependent Enrollment..... A-3

Change in Status A-4

Special Enrollment Rules A-4-A-5

Newborn Children..... A-5

Changes in Coverage..... A-5

Termination of Coverage A-6

Leaves of Absence A-7

Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA)..... A-7

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.

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.

Employees of tax supported organizations as approved by the Plan 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 in the Definition section of this Plan, 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.

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 Plan. 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 31-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.

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.



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 Plan 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 or divorce of an Employee;
2. The legal separation of an Employee, where legally recognized;
3. The death of the Employee's Spouse, or a Dependent;
4. The birth, or adoption of a child of the Employee;
5. The termination or commencement of employment of Employee's Spouse;
6. 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;
7. The taking of an unpaid Leave of Absence by the Employee or Employee's Spouse; or
8. A significant change occurs in the health coverage of the Employee, or Spouse attributable to the Spouse's employment.

ENROLLMENT & ENROLLMENT DATES

New Employees and Dependents Enrolled in a Timely Manner

An Employee may enroll in the Plan for Employee and Dependent coverage on, or before the 31st day following his employment date. Employee Coverage begins on the first day of the fifth (5th) pay period following the date of employment.

The County of Volusia reserves the right to waive the ten (10) week waiting period for contracted employees and elected officials.

New Employees NOT Enrolled in a Timely Manner

If an Employee does not enroll in the Plan in a timely manner or refuses coverage at the time of enrollment, and does not provide proof of other health care coverage to the Plan Administrator, then the Employee will be automatically enrolled in single coverage by the Plan 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 Plan of his or her new election. If an Employee fails to notify the Plan 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 Plan of his election to reduce Coverage. If the Employee notifies the Plan 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 Plan within the first 31-days of employment, you may not enroll in the Plan until the next Annual Enrollment Period and you will be subject to a Pre-Existing Condition limitation of up to 18-months from your Enrollment Date (as described under "Pre-Existing Condition Limitation"). However, if you decline enrollment in the Plan 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 Plan, but only if both:

1. At the time you decline Coverage, you give a written statement to United Benefits, Inc. 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 and an up to 12-month pre-existing condition limitation will apply.

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 Plan until the next open enrollment period as described above.

To verify your eligibility for this special enrollment, the Plan 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 Plan).

In addition, if you have a new Dependent or Dependents as a result of marriage and you are otherwise eligible for coverage under the Plan, 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 Plan, 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.

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 Plan 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.

If a Covered Employee is terminated for cause, Coverage may end on the date of termination. Contact Personnel Services for details if you are on Disability, Leave of Absence, or away from work for other reasons.

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 Plan, 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.

❖ **Retirement (Florida Retirement System)**

Coverage may be continued indefinitely, subject to timely premium payments. To qualify, normal retirement date is 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).

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.

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 18-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.

SECTION B

IN THIS SECTION YOU WILL FIND INFORMATION REGARDING:

General Plan Provisions	B-1-B-3
Deductibles.....	B-1
Co-Insurance Percentage	B-1-B-2
Out-of-Pocket Expense	B-2
Pre-Existing Conditions Limitations	B-3
Your Right to Demonstrate Creditable Coverage	B-3
Covered Medical Expenses.....	B-4-B-11
Medical Benefit Exclusions & Limitations	B-12-B-14
Prescription Drug Limitations and Exclusions	B-15
General Dental Provisions.....	B-16
Covered Dental Expenses.....	B-17
Dental Benefit Limitations.....	B-18
Dental Benefit Exclusions.....	B-19

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, such as calendar year or Lifetime; or any other specific limit imposed upon a benefit, or benefits, by This Plan.

If the Schedule of Benefits also contains a separate Lifetime Maximum for a specified condition, the separate Lifetime Maximum is part of, and not in addition to, the Plan Lifetime Maximum amount.

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, each Deductible amount must be met.

◆ 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. There is no carry-over provision for Pharmaceutical Benefits.

Co-Pay/Co-Payment(s)

A Co-Pay or Co-Payment is the amount that must be paid toward Covered Expenses before the Plan 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.

GENERAL PLAN PROVISIONS (Continued)

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.

For medical services received outside the Network, Covered Expenses are limited to Usual, Customary, and Reasonable Charges. The Covered Member is responsible for any charges exceeding Usual, 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. Benefit payments made under This Plan since its original Effective Date of October 1, 1986, count towards the Lifetime Maximum.

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 Plan'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 be met.

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 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 Plan Administrator has

GENERAL PLAN PROVISIONS (Continued)

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) or for any time accumulated under the "Pre-Existing Conditions Limitations" of the prior plan toward satisfying the Deductible and out-of-pocket amount(s) and "Pre-Existing Conditions Limitations" of This Plan.

Usual, Customary, and Reasonable Charges

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

Pre-Existing Condition means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the "Enrollment Date" (i.e., the first day of coverage or the first day of the Eligibility Waiting Period). Expenses relating to a Pre-Existing Condition are not covered under this Plan until the person has been covered under the Plan for 12-months (18-months for a Late Enrollee) after the Enrollment Date.

This 12-month or 18-month period is reduced by the number of days of Creditable Coverage the individual has as of the Enrollment Date, provided the individual does not have more than a 63-day break in coverage. Neither a waiting period nor an HMO affiliation period is taken into account in determining if a break in coverage occurred. Creditable Coverage includes coverage under a group health plan, individual or group health insurance, Medicare, Medicaid, military coverage, and certain other medical coverage.

The Plan's Pre-Existing Condition limitation does not apply to:

1. Pregnancy;
2. A newborn child; or
3. A child adopted, or placed for adoption before attaining age 18, if such newborn child, or child adopted, or placed for adoption:
 - a. Is enrolled in a group health plan or other Creditable Coverage within 31-days after the birth, adoption, or placement, and
 - b. Does not have more than a 63-day break in coverage.

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 Plan 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 may cover Chiropractic Services for 12 visits per calendar year. After the initial 12 visits, a Treatment Plan must be approved by the Plan if the Covered Member is to receive Coverage for additional services. The Treatment Plan must be filed with the Claims Administrator for the Plan 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

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 Plan 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 Services

This Plan may cover Hospital Emergency Room Services for accidental Injuries and Illnesses and Deductible does not apply. The Emergency Care Service Co-Pay will be waived when the Emergency Room 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 a Medical Emergency basis as defined on page C-20.

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 4

COVERED MEDICAL EXPENSES (Continued)

Fertility Studies and Diagnostic Procedures

Fertility studies and diagnostic procedures are covered to a Lifetime 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 Plan 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 Plan 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 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.

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 4

COVERED MEDICAL EXPENSES (Continued)

Mastectomy Procedures. The Plan 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 Plan 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 for Covered Employees or covered spouses only. Maternity Benefits are not covered for other Dependents. 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); (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 due to cataract Surgery.

Massage Therapy

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

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.

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 4

COVERED MEDICAL EXPENSES (Continued)

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. However, the Co-Payment for Inpatient Hospital admission for a newborn requiring medical care due to premature birth, injury, or illness shall be imposed.

◆ 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.

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
- Ear lavage (wax removal)
- 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.

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 4

COVERED MEDICAL EXPENSES (Continued)

- **Special Transplant Program**

In addition to the standard transplant benefit stated in this booklet, the following benefits may be available when a covered person participates in the SunExcel Special Transplant Program. This Special Transplant Program is an enhancement to the transplant benefit and participation in the program is voluntary.

- **Covered Benefits**

1. Access to approximately 40 transplant Centers of Excellence across the United States, as well as outpatient peripheral stem cell facilities.
2. Reimbursement for travel and lodging expenses incurred during the transplant (immediately prior to and after the transplant) up to a \$5,000 maximum for covered person and a companion. Travel and lodging discounts are also available with select airlines and hotels.
3. Waiver of covered person's deductible and out-of-pocket expenses, up to a \$1,500 maximum.
4. Services of a Transplant Facilitator, who will coordinate the entire process.

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. Pre-notification must be made to 1-888-4ORGANS; and
2. Pre-certification must be obtained from Preferred Physicians Healthcare Alliance (PPHA); 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 1-888-4ORGANS must be made as soon as the covered person is identified as a potential transplant candidate. Once enrolled in the program, a Transplant Facilitator will be assigned and will coordinate the entire process with the patient and physician from hospital selection to travel arrangements to prescription drug options. The Transplant Facilitator will contact United Benefits, Inc. for benefit information, as well as contact the covered person's referring physician for additional information. Information on the program will be forwarded to the covered person and their physician regarding network hospitals and other relevant information. The Transplant Facilitator will work with the covered person, his/her physician, and United Benefits, Inc. to ensure quality and continuity of care throughout the process, pre-transplant to post-transplant, including organ harvest.

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.

TO AVOID PRE-CERTIFICATION PENALTIES, SEE PAGE 4

COVERED MEDICAL EXPENSES (Continued)

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 Plan if the covered member is to receive coverage for additional services. The Treatment Plan must be filed with the Claims Administrator for The Plan 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

A Second Surgical Opinion may be covered by This Plan on the same basis as any other benefit, subject to the Co-Pay.

However, if the Utilization Management service determines that a Second Surgical Opinion is required to determine Medical Necessity, payment will be made at 100% with no Deductible.

The second opinion consultation must be with a Board-Certified Surgeon, who must be neither affiliated in practice with the Surgeon who first recommended Surgery, nor be the Physician performing the Surgery. The consulting Physician must personally examine the Covered Member and send a copy of the written opinion to the Claims Administrator. Benefits include the Physician's charges for the physical examination, laboratory work, X-rays, and related tests not previously performed by the original surgeon.

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

COVERED MEDICAL EXPENSES (Continued)

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.

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;
- e. emergency repair for accidental injuries to natural teeth;
- f. surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth; and
- g. 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 also covered.

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

MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS

This Plan may not pay for and Covered Medical Expenses do not include charges:

1. for care or treatment of hair loss, including wigs (except due to cancer treatment), hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician;
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, Occupational Therapy, or Chiropractic Services where no significant improvement of the condition can be expected as a result of the therapy;
6. related to 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 or instability or imbalance of the feet, or any tarsalgia, metatarsalgia 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;
8. for any medical treatment, procedure, drug, biological product or device which is deemed experimental or investigational by Preferred Physicians Healthcare Alliance (PPHA), based on the most current reliable evidence;
9. for treatment of eating disorders by way of gastric bypass, or gastric stapling; activities or drugs for weight reduction or control of obesity, morbid obesity, or exogenous obesity;
10. for manipulation of the spine requiring Anesthesia;
11. for transplants, except as stated in the provision entitled "Organ or Tissue Transplant Services";
12. for in-vivo or in-vitro fertilization, or medical services or supplies for artificial insemination;
13. 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;

MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS (Continued)

14. for immunotherapy for recurrent abortion;
15. incurred as the result of Pregnancy for Dependents other than a covered spouse;
16. for mechanical contraceptive devices and implantable contraception medications;
17. 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;
18. for vitamin or mineral supplements, or fluoride drugs;
19. for holistic medicine, acupuncture, hypnosis, biofeedback, or forms of self-care or self-help;
20. for marital or family counseling;
21. for telephone consultations, failure to keep scheduled appointments, completion of claim forms, or providing medical information necessary to determine Coverage;
22. for educational or vocational testing or training, or job training;
23. for Custodial Care;
24. for Hospital services and supplies when confinement is primarily for diagnostic testing purposes or Physical Therapy;
25. for the purchase or rental of motorized transportation equipment, escalators or elevators, saunas or swimming pools;
26. 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;
27. 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, Customary, and Reasonable (UCR) charges for medical services provided outside the Network;
28. for medical services or supplies for which benefits are not paid due to the Deductible or Co-Insurance Percentage provisions of This Plan;
29. for any medical treatment not Medically Necessary;
30. for medical services rendered outside the continental United States of America or its territories except for Accidental Injury or a Medical Emergency;
31. for claims not received within twelve (12) months from the date services were incurred;

MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS (Continued)

32. for any medical services or supplies not prescribed by a Physician;
33. for any expense denied by the primary health plan because the claim did not comply with the rules governing that plan of benefits;
34. covered by extended benefits from another group health plan;
35. 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;
36. 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;
37. 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;
38. 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;
39. 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 Plan;
40. 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;
41. 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;
42. 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;
43. for any service or supply which is specifically limited or excluded under any other portion of This Plan;
44. for dental services and supplies except as specified under the "Teeth, Gums and Alveolar Process" provision of This Plan;
45. for diabetic supplies not purchased through the Prescription Drug Program; or
46. for routine colonoscopies for covered members under age 50.

PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS

This Plan will not pay for and Covered Prescription Drugs do not include charges 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. Rogaine (minoxidil) for hair restoration or any other drug used primarily for cosmetic purposes;
4. Retin-A will be covered for all patients 25 and under with a diagnosis of acne vulgaris;
5. Accutane will be covered for all patients 25 and under only for apitic acne;
6. Renova is excluded as a cosmetic product;
7. any over-the-counter medications, excluding insulin;
8. 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, and chemical strips;
9. infertility medications;
10. migraine 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;
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 WHP Mail Service Pharmacy purchases;
17. Prescription drugs which may be properly received without charge under local, state, or federal programs, including Workers' Compensation;
18. Prescription drugs relating to any Pre-existing Condition.

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

GENERAL DENTAL PROVISIONS

Your benefits will be based on the Covered Expenses you incur while covered by This Plan. It is important to know what expenses are covered and the limitations that apply.

This Plan will pay a percentage of your Covered Expenses that exceed or are not subject to a Deductible amount. The Schedule of Dental Expense Benefits shows what percentage you pay for each type of dental service as well as the maximum benefit for this Coverage. Covered Charges are limited to Usual, Customary, and Reasonable; and you are responsible for charges exceeding UCR guidelines.

Free Choice of Dentist

Any Employee or Dependent covered under this Plan will have free choice of his/her Dentist, including Dentists in the SMILE Card Network. **An Employee utilizing a participating SMILE Card Network Dentist will have lower Out-of-Pocket expenses.**

Deductibles

A Deductible is the amount that must be paid toward Covered Expenses before This Plan will start reimbursement.

◆ 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 as a unit accumulate a total of 3 Deductibles during a calendar year.

PRE-DETERMINATION OF BENEFITS

Covered Members contemplating dental work are strongly urged to submit a copy of the Treatment Plan to the Claims Administrator. The Treatment Plan should include a list of the services and procedures to be done, the itemized charges for each service and procedure, and the estimated length of treatment. Dental X-rays, study models, and anything else needed to evaluate the Treatment Plan should also be sent.

The Treatment Plan will be reviewed and the Plan Administrator will determine the benefits available and advise the patient and/or the Dentist of the benefits available before treatment commences.

If a Treatment Plan for pre-determination of benefits is not submitted, the Plan retains the right to pay the claim on the basis of the amount of benefits which would have been paid had a Treatment Plan been submitted for pre-determination of benefits.

Emergency treatment, oral examination, dental x-rays, and teeth-cleaning are part of a course of treatment, but may be done before the pre-determination review is made.

A Treatment Plan should always be submitted before Orthodontic Treatment starts. Total benefits for the course of treatment will then be determined and disbursed as follows:

1. The initial payment will be made when the bands or active appliance is first placed, but will not exceed one-third (1/3) of the total benefit;
2. Further payments will be made on a monthly basis while treatment is continued and the person remains covered by the plan.

COVERED DENTAL EXPENSES

Unless otherwise specified, payment for Covered Dental Expenses will be made at the Co-Payment/Co-Insurance Percentages shown in the Schedule of Dental Expense Benefits, subject to any Deductible amounts, any Limitations, the Definitions, and all other provisions of This Plan.

❖ Type I -- Preventive Services

1. Oral exams, cleanings, and x-rays limited to two (2) visits per calendar year.
2. Topical application of fluoride.
3. Tests and laboratory exams related to dental procedures.
4. X-Rays – Panoramic one (1) per 36 months. Bitewings two (2) per calendar year.

❖ Type II -- Restorative Services

1. Fillings, extractions, space maintainers.
2. Anesthesia.
3. Injection of antibiotics.
4. Periodontal treatment.
5. Endodontic treatment, including root canals.
6. Sealants (Age limit – up to and including age 17).

**Oral Surgery - See Covered Medical Expenses

❖ Type III -- Replacement Services

1. Dentures to replace teeth extracted while covered.
2. Bridgework, including inlays and crowns to form abutments, to replace teeth extracted while covered.
3. Inlays, gold fillings, and crowns, including attachments for dentures.
4. Installing partial or full dentures for the first time due to the extraction of one or more natural teeth extracted while covered.
5. Repair of dentures, crowns, inlays, or bridgework if:
 - a. unserviceable after 5 years; or
 - b. temporary to permanent within 24 months.
6. Relining of dentures. See Limitations.

❖ Type IV -- Orthodontic and Implant Services

1. Orthodontic Treatment, such as braces, including correction of malocclusion.
2. Implants.

DENTAL BENEFIT LIMITATIONS

Dental benefits are limited as follows:

1. An oral exam including prophylaxis will be covered two (2) times each calendar year.
2. Topical application of fluoride for your Covered Dependent child up to the age of 19 will be covered two (2) times each calendar year.
3. Relining of dentures will be limited to once each thirty-six (36) months. The relining of dentures is not covered during the first 6-months following the initial installation of appliance.
4. Replacement of an existing partial or full denture, crown, or fixed bridge is covered only if:
 - a. the existing denture or bridge cannot be made serviceable and was installed at least five (5) years before it is replaced; or
 - b. the existing denture is an intermediate denture and must be replaced by a permanent denture, and the replacement is made within twenty-four (24) months from the date the intermediate denture was installed; or
 - c. the replacement or addition of teeth is required to replace one or more natural teeth extracted while covered and after the existing denture or bridge was installed.
5. Bridges are covered only if they are for replacement of one or more natural teeth that were extracted while covered.
6. Orthodontic Treatment is covered only if the Dentist diagnoses one of the following conditions using the technical classification system for measuring the extent of upper or lower jaw malocclusion:
 - a. Angle's Class I, if:
 - (1) the upper teeth protrude over the lower teeth; or
 - (2) there is an open bite; the front upper and lower teeth do not meet; or
 - (3) there is an arch-length discrepancy; the gum area is too large or too small for the teeth; or
 - (4) there is an extreme bucco-lingual version of teeth; and the teeth are in crossbite.
 - b. Angle's Class II or III.
7. Benefits will be payable only upon completion of the treatment, except in the case of Orthodontic Treatment. Benefits for Orthodontic Treatment will be payable in equal monthly amounts during the period that: (a) begins when the first orthodontic appliance is installed; and (b) ends when the last appliance is originally scheduled to be removed. Such monthly installments will terminate on the date the Covered Member's Coverage terminates.

DENTAL BENEFIT EXCLUSIONS

This Plan will not pay for, and covered dental expenses do not include charges for:

1. the replacement of a lost or stolen prosthetic device;
2. charges that are made by someone who is not a Dentist or for treatment not performed by a Dentist. The cleaning and scaling of teeth may be performed by a licensed Dental Hygienist who works under the supervision of a Dentist;
3. the first installation of dentures or bridges if all teeth that will be replaced were extracted prior to the date the Covered Member became covered under This Plan. Bridges include crowns and inlays that form the abutments;
4. prosthetic devices and their fitting, for which treatment began prior to the date the Covered Member became covered under This Plan. This includes bridges and crowns;
5. extra sets of dentures or other appliances;
6. failure to keep an appointment;
7. completion of any forms;
8. appliances, restoration, and procedures to alter vertical dimension or restore occlusion;
9. services for any treatment which is for cosmetic or aesthetic purposes;
10. charges to the extent that payment under This Plan is prohibited by any law of the jurisdiction in which the Covered Member resides at the time expenses are incurred;
11. infection control, such as gloves, masks, or any related services;
12. home fluoride rinses, toothbrushes and other dental items that can be bought without a Prescription;
13. dental services or supplies for which a Covered Member is not required to pay or for which charges are made only because This Plan exists, subject to the right, if any, of the United States government to recover Customary and Reasonable Charges for care provided in a military or veterans' Hospital;
14. any dental services for which benefits are paid or payable under Workers' Compensation, or any occupational disease, or similar law;
15. any act due to war, if declared or not;
16. any dental services covered by extended benefits from another group dental plan;
17. professional medical services and supplies rendered by the Employee, Employee's spouse, or the children, brother, sisters, parents, or grandparents of either the Employee or the Employee's spouse;
18. services and supplies that are in excess of Usual, Customary, and Reasonable Charges;
19. treatment or procedures deemed experimental or investigative by a nationally recognized dental authority such as the MDR Payment System or the American Dental Association. Where conflicting opinions exist, the nationally recognized agencies will take precedence.

SECTION C

IN THIS SECTION YOU WILL FIND INFORMATION REGARDING:

Your Medicare Supplement Coverage..... C-1-C-2

How to File a Claim..... C-3

Claim Denial and How to Appeal a Denial of Benefits..... C-4

General Claim Provisions C-5-C-6

Coordination of Benefits C-7-C-9

 Integration of Benefits with Medicare C-8

Extension of Benefits after Plan Termination..... C-10

Right of Subrogation C-11-C-12

Continuation of Coverage (COBRA)..... C-13-C-15

Plan Information..... C-16

Definitions C-17-C-27

Health Insurance Portability & Accountability Act Of 1996 (HIPAA) - Privacy Rule..... C-28-C-36

YOUR MEDICARE SUPPLEMENT COVERAGE

SCHEDULE OF BENEFITS

(Applicable only to Retired Employees and their Dependents who qualify for Medicare Coverage)

LIFETIME MAXIMUM BENEFIT\$25,000

DEDUCTIBLE PER CALENDAR YEAR

Medical\$100

COVERED PERCENTAGE Refer to the next page

Covered Medical Expenses. Covered Medical Expenses include only the charges described on the Comparison Chart on the next page. The charges must: (a) not be excluded by other provisions applicable to this Coverage, (b) be necessary for the care, and treatment of Sickness, or Injury of a Covered Member, (c) be recommended by an attending Physician, and (d) not exceed the regular, and customary charges within the area for the services, and supplies furnished. A charge is considered to be incurred on the date a Covered Member receives the services, or supplies for which the charge is made.

Benefits Payable. Benefits are payable in an amount equal to 80% of the Eligible Charges incurred each calendar year in excess of those applied to the Deductible for that year. However, the total amount payable for all such expenses incurred by a Covered Member during his Lifetime will not exceed the appropriate Maximum Benefit stated above.

No Deductible is applied to Hospital Charges. A \$100 Deductible will be applied to all other Eligible Medical Charges.

The Deductible is applied once each calendar year to the applicable expense incurred by each Covered Member. However, if an individual and his spouse sustain injuries in a single Accident, occurring while both are Covered Members, not more than one Deductible will be applied to all Covered Expenses due to such injuries that are incurred in the calendar year in which the Accident occurs. In addition, a Covered Member's Deductible for a calendar year will be reduced by Covered Expenses incurred during October, November, and December of the immediately preceding calendar year that were applied to his Deductible for that year.

The Maximum Benefit for each Covered Member is \$25,000. However, after benefits of \$1,000 have become payable for Eligible Charges incurred by a Covered Member, his Maximum Benefit may be fully restored if he submits satisfactory Evidence of Good Health.

Special Provisions for the Continuation of Dependent Coverage. The Covered Dependent Spouse of a deceased Retiree will be eligible to continue Coverage under This Plan indefinitely provided premium payments are made.

Coverage for any Dependent will cease on the date he, or she (a) attains any maximum age limit, (b) marries, or remarries, (c) becomes covered for similar Coverage as an Employee under a Group Plan administered by the County of Volusia, or (d) ceases to be an eligible Dependent in accordance with any other provisions of the Group Plan not inconsistent with these provisions, if such date occurs before the end of the maximum period.

The Coverage being continued under these provisions will not be terminated, reduced, or increased as the result of Amendments to or termination of the Group Plan occurring after the date of the Retiree's death. However, if any changes are required in such Coverage because of the Dependent's age, such changes will be made in accordance with the provisions of the Group Plan in effect at the time of the Retiree's death.

WHAT MEDICARE PAYS PART A AND PART B

Hospital Expenses - After the current Medicare Hospital Deductible, Medicare pays in full for a semi-private Hospital room and all necessary Hospital services from the 1st through the 60th day each Benefit Period*.

In full for the 61st through the 90th day, for all semi-private rooms and other Hospital charges, except for the current daily Medicare limit.

A Lifetime Reserve of 60-days of in-patient Hospital care after the regular 90 days of coverage have been used up, except for the current daily Medicare limit.

***A Benefit Period** under Part "A" begins on the first day you receive services as a patient in a Hospital or extended care facility and ends after you have been out of a Hospital or extended care facility for 60 consecutive days.

Physician Services (in a Hospital, office or at home)

and

Other Covered Medical Care (i.e. home health visits by a visiting Nurse, diagnostic tests, portable x-ray services, dressings, casts, oxygen tents, wheelchairs, artificial limbs and eyes, ambulance services or out-patient Physical Therapy services.)

After the \$100 yearly Deductible, Medicare pays 80% of reasonable charges. Except that Medicare pays 100% of Reasonable charges for in-patient x-ray and pathology services.

Private Duty Nursing Services (outside of Hospital setting.) Must not be provided by a member of your family. NO COVERAGE UNDER MEDICARE.

Prescription Drug Charges - NO COVERAGE UNDER MEDICARE.

Expenses for cost of blood - NO COVERAGE UNDER MEDICARE.

WHAT HEALTH PARTNERSHIP PLAN MEDICARE SUPPLEMENT PAYS

The Supplement pays the Medicare in-patient Hospital Deductible for each Benefit Period*, then

The current daily Medicare limit for the 61st day through the 90th day, then

The current daily Medicare limit, up to the maximum 60 day Lifetime Reserve, then

All eligible Hospital expenses after Medicare benefits are exhausted. (Limited to Hospital's semi-private room rate, or 80% of the lowest private room rate, if the Hospital has no semi-private rooms.)

Subject to \$100 yearly medical Deductible, the Supplement pays:

80% of the Medicare Co-Payment for expenses for Medical and other health services received during each calendar year.

50% of the expenses for Medical and other health services received during each calendar year which exceed the regular and customary charges under Part B of Medicare.

The Supplement pays for private duty nursing services by a Registered Nurse if prescribed by a Physician. Must not be provided by a member of your family.

Prescription Drug Expenses for drugs and medicines obtainable only on a Physician's Prescription, excluding those received in a Hospital or administered by a Physician as an incident of his professional service.

The Supplement pays for the reasonable cost of the first three (3) pints of blood.

HOW TO FILE A CLAIM

1. Complete the "Employee" portion of the claim form.
2. If payment is to be made directly to the provider, sign the "Authorization To Pay Provider" statement.
3. Have the patient or parent sign the "Authorization To Release Information" statement.
4. For the initial claim, attach the provider's itemized bill to the completed claim form. The itemized bill must include:
 - *Name and Social Security Number of the Insured
 - *Name of the Patient
 - *Name and Address of the Provider
 - *Type of Services Rendered
 - *Diagnosis
 - *Date of Services
 - *Charges
5. If the Employee does not have the actual itemized bill, have the Physician, or Dentist complete their respective section on the back of the claim form.
6. If claims are being made for several family members, complete a separate claim form for each individual.
7. Mail completed claim forms and itemized bills to:

**United Benefits, Inc.
220 S. Ridgewood Avenue
P.O. Box 2480
Daytona Beach, FL 32115-2480**

Only one claim form per year for dental, needs to be completed for any Covered Member requesting benefit payments. The provider's itemized bill will be sufficient for any additional claims requests, providing it contains the information listed in #4.

A Medical claim form will be requested as required.

All claims should be filed immediately, but **must be filed within 12 months** of the date charges for the service were incurred.

Explanation of Benefits

The Explanation of Benefits explains what expenses This Plan will pay for, and what expenses you must pay for. You will receive an Explanation of Benefits for every claim processed.

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 United Benefits, Inc., 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 Plan 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 the Covered Person will be advised of the reason for the denial with specific reference to The Plan 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 you are not satisfied with that 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 Plan Administrator, Personnel Division Benefits Section.

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 Physicians Healthcare Alliance (PPHA), 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 Plan 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 Plan 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

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 Plan'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 Plan Administrator in writing, when a clerical error has occurred, or a delay in making entries in the records pertaining to the Coverage under the Plan 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 Plan Administrator will have the right to request, or release any medical information it deems necessary to properly process a claim.

The Plan 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.

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 Plan with respect to which the terms of the Plan 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 Plan that is not a “Pre-Service” claim.

COORDINATION OF BENEFITS

The benefits that are payable under This Plan for medical, or dental 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 any Totally Disabled Employee or 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 reduced by the amount of any benefits payable under Medicare, whether or not the Covered Member has enrolled in Part A or Part B of Medicare.

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 Plan 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 Plan Administrator.

Right to Make Payment

The Plan 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 Plan 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 Plan 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 dental 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.

RIGHT OF SUBROGATION

Exclusion. The plan does not cover medical expenses or other benefits if a person (other than the person for whom a claim is made) is or may be responsible for the injury, illness, disease, or other condition giving rise to the expenses or benefits, irrespective of whether litigation has been initiated. The amounts excluded under this provision are referred to as “Excluded Benefits.”

Discretionary Payment By Plan. If, at the time the claim is received, payment for the Excluded Benefits by or for the responsible person has not yet been made, the plan administrator, in his sole discretion, may elect to advance to the covered person benefits otherwise payable (the “Advanced Benefits”) if the covered person and his or her attorney, if any:

- (a) Agree to and observe the terms and conditions of this Section;
- (b) Agree to reimburse the plan for the Advanced Benefits from any recovery in the manner set forth in the next paragraph;
- (c) Agree to take such action, give such information, records and assistance the plan requests to help it enforce its rights;
- (d) Sign (within 60 days of the plan’s request) any subrogation and/or reimbursement agreements, assignment, or any other documents the plan requests to help it enforce its rights (however, even if the covered person and/or his or her attorney, if any, fail to sign any such agreement or assignment and the plan advances benefits, the plan’s rights to recover the Advanced Benefits under paragraph three (3) and four (4) shall not be impaired;
- (e) Keep the plan apprised of the status of all proceedings and settlement negotiations to protect the plan’s interest in any settlement or judgement;
- (f) Tell the plan about any claim he or she may have against any and all potentially responsible parties;
- (g) Notify the responsible person or its insurer about the plan’s subrogation and reimbursement rights; and
- (h) Fully cooperate with the plan in enforcing its rights.

If the covered person and his or her attorney, if any, fail to comply or indicate an unwillingness to comply with each of the requirements listed above, the plan administrator may, in his sole discretion, refuse to pay any part or all of the Excluded Benefits with the respect to the accident or illness in accordance with the first paragraph.

Reimbursement Right. By accepting payment of benefits from the plan, the covered person and his or her attorney, if any, agrees to reimburse the plan for such benefits from the first dollar of each and every recovery from each responsible party or insurance carrier until the full amount of the Advanced Benefits have been repaid. This includes recoveries by judgement, settlement, under an automobile insurance policy, under “no fault” automobile legislation, from the covered person’s own uninsured motorist carrier, or in any other way to or on behalf of the covered person or his or her successor in interest (including by way of illustration and not limitation his or her personal representatives, heirs, or assigns).

- (a) **Deadline for Repayment; Interest.** The covered person and his attorney, if any, must make this reimbursement to the plan within 15 days after receiving each recovery or portion thereof. If payment is made to the plan later than this 15-day deadline, the unpaid amount will bear interest at 3% per month, compounded monthly (or if less, at the maximum rate permitted by applicable law).

RIGHT OF SUBROGATION (Continued)

- (b) Plan Priority. The plan's reimbursement right applies to a recovery of all the relief the covered person or his or her attorney sought (i.e., even if the covered person was not "made whole" by the recovery) and even if the recovery does not separate medical expenses from other items of damages, including pain and suffering.
- (c) No Reduction for Attorney's Fees, Etc. The amount payable to the plan to repay benefits shall not be reduced by attorney's fees, expenses, or costs incurred by the covered person or his or her attorney to obtain any such recovery or by any other amount.
- (d) Allocations Disregarded. Notwithstanding any allocation made in a settlement agreement or court judgement, for all purposes of the plan's right of reimbursement, any monies recovered from any responsible person shall be deemed to reimburse the covered person first for the Advanced Benefits.
- (e) Offset Against Other Benefits. Amounts due to the plan to repay the Advanced Benefits (under this provision, as an overpayment, or under any other plan provision) may, at the plan's option, be deducted from other benefits payable by the plan to the covered person or any covered family member of the covered person.

Subrogation Right. As security for its reimbursement right, the plan will be subrogated to all rights of recovery the covered person has against the responsible person to the extent the plan has paid benefits.

- (a) Optional Enforcement. The plan may choose not to enforce its subrogation right, but this will not waive the plan's separate reimbursement right.
- (b) Settlements Without Plan's Consent Void. No waiver, release of liability, or other documents executed without the consent of the plan will be binding on the plan and will not prejudice the plan's right of recovery against any third party.

Limitations Period. The plan shall have three (3) years from the later of:

- (a) The date of a recovery by the covered person against a third party or
- (b) The date the covered person notifies the plan in writing of the recovery, to bring an action against the covered person to enforce the plan's reimbursement right with the respect to that recovery.

Attorney's Fees. If the plan obtains the services of an attorney to enforce its subrogation and/or reimbursement rights (if, for example, the covered person and his or her attorney, if any, fail to cooperate with the plan in enforcing the plan's subrogation and/or reimbursement rights), the covered person and/or his or her attorney, if any, agree to reimburse the plan out of any recovery from the responsible party or insurance carrier for the attorney's fees and costs the plan incurred.

CONTINUATION OF COVERAGE (COBRA)

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), some covered Employees and/or their covered Dependents described below (called "qualified beneficiaries") are entitled to elect a temporary continuation of health Coverage (called "continuation Coverage") at group rates in certain instances (called "qualifying events") where Coverage under the plan would otherwise end.

An Employee covered by the plan has a right to elect continuation Coverage if Coverage is lost because of the termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment.

The covered spouse of an Employee covered by the plan has a right to elect continuation Coverage if they lose group health Coverage under the Plan for any of the following reasons:

1. The death of the Employee;
2. A termination of the Employee's employment (for reasons other than gross misconduct), or reduction in the Employee's hours of employment;
3. The divorce from the Employee;
4. The legal separation from the Employee, where legally recognized; or
5. The Employee becomes entitled to benefits under Medicare.

In the case of a covered Dependent child of an Employee covered by the Plan, such child has the right to elect continuation Coverage if group health Coverage under the Plan is lost for any of the following reasons:

1. The death of the Employee;
2. The termination of the Employee's employment (for reasons other than gross misconduct), or a reduction in the Employee's hours of employment;
3. The Employee's divorce;
4. The Employee's legal separation, where legally recognized;
5. The Employee becomes entitled to benefits under Medicare; or
6. The Dependent ceases to be a "Dependent child" under the Plan.

Children born to, or placed for adoption with, the 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 Plan after the birth, or placement for adoption.

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

The Employee, or a covered Dependent has the responsibility to inform the Employer within 60-days of a divorce, legal separation, or a child losing Dependent status under the Plan. If the Employee, or covered Dependent does not notify the Employer within this 60-day period, the covered Dependent will not be entitled to elect continuation Coverage.

COBRA CONTINUATION OF COVERAGE (Continued)

Upon notification, the Employer will, in turn, notify the eligible COBRA participant that they have the right to elect continuation Coverage. They have 60-days from the date they would lose Coverage because of one of the events described above, or the date of the COBRA notice, whichever is later, to inform the Employer that they want continuation Coverage.

If they do not elect continuation Coverage, group health Coverage will end effective back to the date of the qualifying event described above.

If they elect continuation Coverage, the Plan will continue the COBRA participant's group health Coverage which, as of the time Coverage is being provided, is identical to the Coverage provided under the Plan to similarly situated Employees, or Dependents.

Continuation of Coverage may be maintained for 36-months unless group health Coverage is lost because of a termination of employment, or reduction in hours. In that case, the continuation Coverage period is 18-months. The 18-months may be extended to a maximum of 36-months if a second event entitling a covered Dependent to continuation Coverage (such as a death, divorce, legal separation, the Employee's Medicare entitlement, or a child losing Dependent status under the Plan) occurs during that 18-month period. However, if the Employee becomes entitled to Medicare during the 18-month period **prior** to a qualifying event that is an employment termination or reduction in hours, COBRA coverage can continue for covered dependents for only up to 36-months **after** the Employee became entitled to Medicare. To qualify for this extension, the Employee, or covered Dependent must notify the Employer within 60-days after the death, divorce, legal separation, the Employee's Medicare entitlement, or child losing Dependent status under the Plan. If the Employee, or covered Dependent does not notify the Employer within this 60-day period, the covered Dependent will not be entitled to extend the 18-Month period to 36-months.

For certain disabled qualified beneficiaries, the 18-Month maximum period of continuation Coverage (because a covered Employee's employment is terminated, or his hours are reduced) may be extended to 29-months. This extension applies to all other qualified beneficiaries who have COBRA coverage because of the same qualifying event. To qualify for the extension of the maximum period of continuation Coverage to 29-months:

1. the Social Security Administration must have determined that the qualified beneficiary was disabled according to Title II (Old Age, Survivors, and Disability Insurance), or Title XVI (Supplemental Security Income) of the Social Security Act at any time during the first 60-days of continuation coverage; and
2. the qualified beneficiary must provide a copy of the determination to United Benefits, Inc. before the end of the original 18-month period of continuation Coverage and within 60-days of the Social Security disability date of determination.

In all cases, continuation Coverage will end for any of the following reasons:

1. The Employer no longer provides group health Coverage for any of its Employees;
2. The appropriate payments for continuation Coverage are not made timely by the COBRA participant(s);

COBRA CONTINUATION OF COVERAGE (Continued)

3. After the date of the COBRA election, COBRA participant(s) become covered under another group health plan that does not contain a pre-existing condition exclusion, or limitation which affects them (under the new portability laws, the time the other health plan can exclude coverage for pre-existing conditions is generally reduced by the number of months you had coverage for the condition under a previous health plan, including other COBRA coverage);
4. After the date of the COBRA election, Participants, or their Dependents become entitled to Medicare;
5. Participants, or their Dependents extended continuation coverage to 29-months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
6. A Participant, or their Dependent notifies the Employer they wish to cancel COBRA continuation Coverage.

You will be required to pay the full cost, or premium for your continuation coverage, plus an administrative fee equal to 2% of the Plan's cost of covering a similarly situated individual to whom a qualifying event has not occurred. A person who is covered for 29-months instead of 18-months because of disability must generally pay 150% of the cost for the extra 11-months of coverage.

Payments for continuation Coverage have to be made within 45-days from the date of election for the initial payment. 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 payment is made, and received. Subsequent payments are due on the first day of each month of Coverage. Premiums are delinquent if not paid 30-days later, in which case Coverage will cease without notice retroactive to the first day of the month. A check that is dishonored for any reason will not be considered payment.

Notification of Address Change - To insure all Covered Participants, and Dependents receive information properly and efficiently, it is important that you notify United Benefits, Inc. at the address listed below of any address change for both the Employee, and any Dependent as soon as possible. Failure on your part to do so may result in delayed COBRA notifications, or a loss of continuation coverage options.

United Benefits, Inc.
P.O. Box 2480
Daytona Beach, FL 32115-2480

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 Plan Administrator: County of Volusia
Personnel Services
123 W. Indiana Avenue
Deland, FL 32720-4607

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, 2004

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: United Benefits, Inc.
220 S. Ridgewood Avenue
Suite 410
P.O. Box 2480
Daytona Beach, FL 32115-2480

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.

However, in order to reduce the risk of unexpected, catastrophic claims loss to your Plan, your Employer has purchased excess loss coverage which provides reimbursement to your Plan in excess of certain dollar amounts.

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.

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, 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.

DEFINITIONS (Continued)

Chiropractic Services (Spinal Manipulation) means the detection and correction, by manual, or mechanical means, of the interference with nerve transmissions, and expressions resulting from distortion, misalignment, or dislocation of the spinal (vertebrae) column.

Claims Administrator is United Benefits, Inc., 220 S. Ridgewood Avenue, P.O. Box 2480, Daytona Beach, FL 32115-2480.

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)

Dental Hygienist means someone who is currently licensed to practice dental hygiene by the state in which he or she practices, and who is acting under the supervision and direction of a Dentist.

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 unmarried children.

The term "**spouse**" means the legally recognized marital 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.

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 with no pre-existing conditions limitations applied provided the Dependent 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 Plan 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, with no pre-existing conditions limitations applied provided the Dependent 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 19. However a child will remain a Dependent until the end of the calendar year in which the child reaches the age of 25 provided the child meets all of the following:

- a. the child is principally Dependent upon the Employee for the majority of support and maintenance; and
- b. the child remains unmarried; and
- c. the child is living in the household of the Employee, unless:
 - i. the child is a full-time, or part-time student; or
 - ii. a Qualified Medical Child Support Order exists.

If the employee fails to notify the Plan 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.)

DEFINITIONS (Continued)

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 the Employee 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 Plan 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, or dental 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 Hospital equipped to furnish care to prevent the death, or serious impairment of the Covered Member.

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.

DEFINITIONS (Continued)

Employee Assistance Plan (EAP) is a completely confidential counseling service to help Employees and family members deal with personal problems that may cause productivity at work to suffer. Short-term counseling is currently provided by The Allen Group (TAG).

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.

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; or
7. A significant change occurs in the health coverage of the Employee, or Spouse attributable to the Spouse's employment.

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.

Home Health Care means a program of medical care and treatment, provided by a public, or private agency or organization, licensed and operated according to the law, that is provided in the home.

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.

DEFINITIONS (Continued)

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-hours 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.

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.

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.

DEFINITIONS (Continued)

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; infirmity-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.

Network Providers mean a participating Physician, Hospital, Qualified Practitioner, 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.

DEFINITIONS (Continued)

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 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 Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

The Plan Administrator for This Plan is County of Volusia, 123 W. Indiana Avenue, Deland, FL 32720-4607.

Plan; This Plan whenever used herein without qualification will mean the Plan 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 Plan.

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.

DEFINITIONS (Continued)

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.

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.

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.

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;

DEFINITIONS (Continued)

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.

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.

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.

DEFINITIONS (Continued)

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 individual 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, 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, Customary, and Reasonable Charges are based on the amounts set forth by MDR 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.

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

For dental expenses the Usual, Customary, and Reasonable Charges are based on the amounts set forth by MedIndex 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.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) - PRIVACY RULE

The following employees or classes of employees under the control of the Plan Sponsor may be given access to individual PHI received from the Group Health Plan or from a health insurance issuer servicing the Plan.

- A. Personnel Division – Benefits Section
- B. Personnel Director
- C. Management Committee

Following is the County of Volusia's Notice of Privacy Practices.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how protected health information may be used or disclosed by your Group Health Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your protected health information, and describes your rights to access and control your protected health information.

Protected health information (or "PHI") is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices has been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact: Ruth Moorman, Senior Personnel Officer, 736-5951.

EFFECTIVE DATE

This Notice of Privacy Practices becomes effective on April 14, 2003.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your protected health information. We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to protected health information, and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all protected health

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) - PRIVACY RULE (Continued)

information that we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the contract holder for your member contract.

Primary Uses and Disclosures of Protected Health Information

The following is a description of how we are most likely to use and/or disclose your protected health information.

▪ ***Payment and Health Care Operations***

We have the right to use and disclose your protected health information for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

> ***Payment***

We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your protected health information when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

> ***Health Care Operations***

We will use or disclose your protected health information to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your protected health information: (i) to provide you with information about one of our disease management programs; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

▪ ***Business Associates***

We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose protected health information, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our Third Party Administrator, United Benefits, Inc., which pays the claims for our Group Health Plan. Walgreens Health Initiatives is a business associate which handles the pharmacy portion of the health plan .

▪ ***Other Covered Entities***

We may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) - PRIVACY RULE (Continued)

protected health information to a health care provider when needed by the provider to render treatment to you, and we may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your protected health information with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

- ***Plan Sponsor***

We may disclose your protected health information to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

Other Possible Uses and Disclosures of Protected Health Information

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your protected health information.

- ***Required by Law***

We may use or disclose your protected health information to the extent that federal law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

- ***Public Health Activities***

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose protected health information, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

- ***Health Oversight Activities***

We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) - PRIVACY RULE (Continued)

- ***Abuse or Neglect***

We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your information if we believe that you have been a victim of abuse, neglect, or domestic violence.

- ***Legal Proceedings***

We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

- ***Law Enforcement***

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (3) it is necessary to provide evidence of a crime that occurred on our premises.

- ***Coroners, Medical Examiners, Funeral Directors, and Organ Donation***

We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

- ***Research***

We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

- ***To Prevent a Serious Threat to Health or Safety***

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

- ***Military Activity and National Security, Protective Services***

Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) - PRIVACY RULE (Continued)

- ***Inmates***

If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

- ***Workers' Compensation***

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

- ***Others Involved in Your Health Care***

Using our best judgment, we may make your protected health information known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

If you are not present or able to agree to these disclosures of your protected health information, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Required Disclosures of Your Protected Health Information

The following is a description of disclosures that we are required by law to make.

- ***Disclosures to the Secretary of the U.S. Department of Health and Human Services***

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

- ***Disclosures to You***

We are required to disclose to you most of your protected health information in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your protected health information that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

We will disclose your protected health information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose protected health information to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) - PRIVACY RULE (Continued)

Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

Other Uses and Disclosures of Your Protected Health Information

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

YOUR RIGHTS

The following is a description of your rights with respect to your protected health information.

▪ ***Right to Request a Restriction***

You have the right to request a restriction on the protected health information we use or disclose about you for payment or health care operations.

We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

You may request a restriction by calling us at the number/writing to Ruth Moorman, Senior Personnel Officer, Personnel Division, 368/736-5951; 123 West Indiana Avenue, DeLand, FL 32720-4607. It is important that you direct your request for restriction to this number/address so that we can begin to process your request. Requests sent to persons or offices other than the number/address indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

▪ ***Right to Request Confidential Communications***

If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

You may afford yourself confidential communication by calling/writing Ruth Moorman, Senior Personnel Officer, 386/736-5951; 123 West Indiana Avenue, DeLand, FL 32720-4607. It is important that you direct your request for confidential communications to this number/address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) - PRIVACY RULE (Continued)

We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your protected health information with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your protected health information could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (e.g., an EOB).

Unless you have made other payment arrangements, the EOB (in which your protected health information might be included) will be released to the plan participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within five business days. Prior to receiving the information necessary for this request, or during the time it takes to process it, protected health information may be disclosed (such as through an Explanation of Benefits, "EOB"). Therefore, it is extremely important that you contact us at the number listed in the summary page of this Notice as soon as you determine that you need to restrict disclosures of your protected health information.

If you terminate your request for confidential communications, the restriction will be removed for *all* your protected health information that we hold, including protected health information that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your protected health information will endanger you.

▪ **Right to Inspect and Copy**

You have the right to inspect and copy your protected health information that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your protected health information that is contained in a designated record set, you must submit your request by calling us at the number listed in the summary page of this Notice. It is important that you call this number to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the one indicated might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) - PRIVACY RULE (Continued)

reviewed. To request a review, you must contact us at the number provided in this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

- ***Right to Amend***

If you believe that your protected health information is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by calling/writing to Ruth A. Moorman, Senior Personnel Officer, Personnel Division, 386/736-5951; 123 West Indiana Avenue, DeLand, FL 32720-4607. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to this number/address so that we can begin to process your request. Requests sent to anyone or offices, other than the one indicated might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

- ***Right of an Accounting***

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of protected health information will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to Ruth Moorman, Senior Personnel Officer, Personnel Division. It is important that you direct your request for an accounting to this address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

- ***Right to a Paper Copy of This Notice***

You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) - PRIVACY RULE (Continued)

COMPLAINTS

You may complain to the Privacy Officer, Michael D. Lary, Personnel Director, if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at 386/736-5951. A copy of a complaint form is available from Personnel or available on ENN.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or any other way retaliate against you for filing a complaint with the Secretary or with us.

AUTHORIZATION FORM
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 Ruth Moorman in Personnel Services, 123 W. Indiana Avenue, DeLand, or emailed to rmoorman@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

PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

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

**United Benefits, Inc.
P. O. Box 2480
Daytona Beach, FL 32115-2480**

We, The Plan Sponsor, recognize 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 Plan.

Plan Sponsor/Plan Administrator: COUNTY OF VOLUSIA

Signed (authorized representative of Plan Sponsor)

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 Coverages 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
- Dental 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 in 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, 2004.

COUNTY OF VOLUSIA

Date: _____

By: _____
Signature

Print Name & Title of Signatory