Plan Document

For the

Board of County Commissioners

Manatee County, Florida

Employee Benefit Plan

Effective Date: January 1, 1994

Table of Contents

SCHEDULE OF BENEFITS

For persons eligible to be covered under

MANATEE COUNTY GOVERNMENT EMPLOYEE BENEFIT PLAN

Effective Date: January 1, 1994

Plan Sponsor: Board of County Commissioners, Manatee County, Florida

Participating Constitutional Officers/Agencies:

Board of County Commissioners

Clerk of Circuit Court

Housing Authority

Property Appraiser

Sheriff of Manatee County

Tax Collector

Supervisor of Elections

Port Authority

Summary of Coverage

The Summary of Coverage is issued merely as a brief description of the Coverage provided under the Plan. It should be understood that the Summary is not a contract and does not contain all the Plan details. The Provisions principally affecting you as described herein are subject to all the terms, conditions and provisions of the Plan Document. You are entitled to this coverage if you are eligible in accordance with the Plan Document. No clerical error will invalidate your coverage, if otherwise validly in force.

INTRODUCTION

This document describes eligibility, covered services and rules and guidelines of the benefits under the Manatee Your Choice Health Plan (the "Plan"). Questions regarding the benefits or procedures for obtaining Covered Health Services may be directed to Employee Health Benefits. The Manatee County Board of County Commissioners is the Plan Sponsor under this Plan.

The Plan's terms and conditions are subject to change from time to time. The document governing this Plan consists only of the Plan Document. No person or entity has any authority to make any oral changes or amendments to the Plan without Board approval.

The Manatee Your Choice Health Plan is a Preferred Provider Plan (PPO). The Plan is self-funded by the County and is administered by Aetna. The Aetna POSII (Open Access) Network is a national network providing a comprehensive group of medical, behavioral health and dental providers (Aetna PPO/PDN Network) to the members of the health plan. Covered Health Services may be obtained either within the Aetna POS II (Open Access) Network or outside the Network. Covered Health Services obtained within the Network are reimbursed at a higher level than those Covered Health Services obtained outside the Network.

Only Covered Health Services are covered under the Plan. The fact that a Physician has prescribed or performed treatment does not mean that it is a Covered Health Service under the Plan. Coverage under the Plan will take effect for an Eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan and enroll in the Plan.

The Plan Sponsor shall have sole and exclusive discretion in interpreting the benefits covered under the Plan and the other terms, conditions, limitations and exclusions set out in the Plan Description and this Summary Plan Description, in making factual determinations related to the Plan, its benefits, and Covered Person and in construing any disputed or ambiguous terms. All determinations and interpretations made by the Plan Sponsor and other such fiduciaries of the Plan are intended to be conclusive and binding on all parties.

To be reimbursed for Covered Health Services you must give the Plan all the information required to process the claim. If you do not provide the required information, you may not be reimbursed.

The Plan may, in certain circumstances for purposes of overall cost savings or efficiency and in its sole discretion, cover services which would otherwise not be Covered Health Services. The fact that the Plan does so in any particular case shall not in any way be deemed to require it do so in other similar cases.

The Plan Sponsor may, from time to time, delegate such discretionary authority to other persons or entities providing services in regard to the Plan and such delegations may include the right to redelegate such authority.

The Plan Sponsor reserves the right at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add benefits or terminate the Plan or the Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants or their beneficiaries. The Plan Sponsor will, whenever practicable, provide reasonable notice to Plan participants or their beneficiaries of any material changes to the Plan.

All participating agencies in the Plan are required to follow the BCC guidelines for employee participation and eligibility; this includes the adoption that each employee contributes to the medical plan.

Notice regarding Personal Health Information: As a HIPAA "covered entity" Manatee Your Choice Health Plan (the Plan) will protect the privacy of Plan Member PHI as required by HIPAA. Notice is given that the Plan may use or disclose PHI pursuant to applicable HIPAA regulations, including but not limited to 45 C.F.R. 164.506. The complete Manatee County HIPAA-compliance statement may be reviewed at www.mymanatee.org.

For services rendered after its effective date, this Plan Document supersedes all brochures or booklets you may have received previously.

NOTICE TO EMPLOYEES

This Plan is a self-insured group health plan regulated by the insurance regulating authorities of the State of Florida. Payment of claims is completely dependent upon the financial solvency of the Plan Sponsor. No guaranty fund exists to cover claims a bankrupt or otherwise insolvent employer or Plan Sponsor cannot pay. As a Plan sponsored by a governmental Employer, the Plan is not subject to the Employee Retirement Income Security Act (ERISA).

GRANDFATHERED HEALTH PLAN

The Board of County Commissioners believes this Plan to be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

According to guidelines set forth by the Affordable Care Act, the YourChoice Health Plan does provide minimum essential coverage and the health coverage meets the minimum value standard for the benefits it provides.

FRADULENT USE OF THE PLAN

Coverage under the Plan may be terminated for failure to comply with the terms of the Plan or to cooperate with the reasonable administration of the Plan.

1. If a Covered Person fails to cooperate in the administration of the Plan, in accordance with the Plan Document, his or her coverage may be terminated upon **thirty (30)** days written notice from the Plan Sponsor.

2. If a Covered Person knowingly gives or allows to be given to the Plan Sponsor or its representative's incorrect or incomplete information about himself or herself, or another covered person, the coverage of the Covered Person who gave the information or on whose behalf it was given may be terminated upon thirty (30) days written notice from the Plan Sponsor. The Covered Person shall be responsible for all costs incurred by the Plan because of misrepresentation.

3. If the Covered Person permits the use of the Plan Identification Card by another person, or uses someone else's card, it may be kept by the Plan and the Covered Person's coverage terminated upon thirty (30) days written notice. The Covered Person shall be liable to the Plan for costs resulting from misuse of the card.

4. If a Covered Person sells or gives prescription drugs obtained for their own use under the Plan to another person the Covered Person's coverage will be terminated upon thirty (30) days written notice. The Covered Person shall be liable to the Plan for the Prescription Drug benefits paid for the subject Prescription Drugs.

   Effective January 1, 2012, any employee or retiree who, after receiving notice of outstanding premium payment, and who thereafter continues to owe premiums, shall be dropped from the Plan 45 days from initial notice. Active Employees who wish to re-enroll in the Plan at a later date must wait until a qualifying status change or the next annual enrollment period and will be considered as a new enrollee and will be required to follow all of the guidelines outlined in the Plan Document.

COST OF COVERAGE-CONTRIBUTORY

This plan provides coverage for medical benefits, behavioral health benefits, prescription drug benefits, and dental benefits. The coverage under the plan is "contributory." This means that while the Employer may in its sole discretion contribute a portion of the premium cost on behalf of covered individuals, participants in the plan must also make contributions toward the cost of coverage.

The Plan contracts with a reinsurance carrier for stop loss coverage on a specific basis to protect the Plan and its participating members in catastrophic claims.

In addition to premium contribution by the County, the employer may contribute an additional amount towards incentives for participating in and/or achieving the established goals of the various programs the Plan has designed. If it is unreasonably difficult due to a medical condition for a member to achieve the standards for the reward under a particular program, or if it is medically inadvisable for members to attempt to achieve the standards for the reward under this program, alternative ways will be developed to assist the member to earn the reward.

SECTION 1 - ELIGIBILITY AND ENROLLMENT

1.00. ENROLLMENT

1.00.01 ELIGIBILITY DATE

The date the person is allowed to enroll in this Plan, after completing the waiting period.

Waiting Period

The Waiting Period for coverage ends the first of the month following 30 days of full-time active service employment.

For this purpose, an Employee is deemed to be in active employment or active service if an absence from work is due to a sickness or bodily injury, provided the individual otherwise meets the definition of active employee.

Employee Enrollment

An Employee enrolls for Employee coverage by:

- completing an enrollment session in the Benefit Administrative system

An Employee's enrollment must be timely.

- an Employee's enrollment is considered timely if he or she enrolls during the Initial Eligibility Period, a Special Enrollment Period (FSC), or during the Annual Enrollment Period.

Dependent Enrollment

An Employee must enroll for coverage as an Employee in order to enroll his or her Dependents.

An Employee enrolls his or her Dependents for coverage by:

- completing an enrollment session in the Benefit Administrative system, identifying each eligible Dependent; and
- uploading applicable documentation to verify proof of Dependent eligibility.

Initial Dependents are those who are eligible Dependents on the date the Employee first becomes eligible for Employee coverage under this Plan.

Subsequent Dependents are those who become eligible Dependents after the date the Employee first becomes eligible under this Plan. Subsequent Dependents may be added during a Special Enrollment Period with proof of dependency.

A Dependent is considered a timely enrollee when he or she is enrolled for coverage during either the Initial Eligibility Period or a Special Enrollment Period (FSC) or Annual Enrollment Period.

Enrollment Periods

The Initial Eligibility Period is the 30 day period which begins on the date the Employee or Dependent is first eligible under this Plan.

Employees and/or Dependents who are not enrolled during the Initial Eligibility Period or a Special Enrollment Period must wait until the next Open Enrollment Period (typically November) to enroll for coverage to be effective the next designated Plan Year.

Special Enrollment Periods are available to Employees who were determined to be ineligible because of a failure to satisfy the definition of Full Time Employee, upon their becoming reclassified as Full-Time Employees, as permitted under the Affordable Care Act.

Special Enrollment Periods are available to certain persons who have lost other coverage and to certain dependents according to Family Status Change Guidelines.

A Special Enrollment Period is available to a person who meets each of the following conditions according to the Family Status Guidelines:

- The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the Employee or Dependent.

- The Employee's or Dependent's prior coverage was one of the following:

    - COBRA continuation which was exhausted.

    - Non-COBRA coverage which was terminated whether as a result of loss of eligibility for the coverage (including as a result of, divorce, death, spouse's employer sponsored annual enrollment, termination of employment, or reduction in the number of hours or employment) or employer contributions towards such coverage were terminated.

- The Employee requests enrollment under this Plan not later than 31 days after the date of the end of the COBRA continuation, termination of coverage, or termination of Employer contribution with proof of termination must submit a prior Certificate of Coverage.

A Special Enrollment Period is available to Subsequent Dependents. The Dependent Special Enrollment Period is the 31-day period which begins with the date the person becomes a Dependent.

If a Subsequent Dependent is enrolled, the Employee must enroll at the same time if not already covered. In addition, any of the Employee's other Dependents may be enrolled at the same time, if not already covered, subject to the same enrollment requirements.

1.00.02 EFFECTIVE DATE OF EMPLOYEE COVERAGE

Employee Coverage is effective on the first day of the month following: the date the Employee completes a Waiting Period of 30 days of **Active Full Time** Service.

1.00.03 EFFECTIVE DATE OF DEPENDENT COVERAGE

Coverage for Initial Dependents, with Proof of Eligibility is effective as follows:

- The date the Employee's coverage becomes effective.

Coverage for a Subsequent Dependent is effective as follows:

- For a spouse, first of the month following the date of marriage.

- For a newborn, the date of birth as long as the newborn is enrolled within 60 days of birth.

- For an adopted child, the date of placement of the child for adoption.

- For any other child, first of the month following the date the child becomes a Dependent.

1.01 ELIGIBLE PERSONS

1.01.01 EMPLOYEE COVERAGE

Eligible Employees are:

All Full-Time Employees (as defined by the Affordable Care Act Guidelines-averaging 30+ hours per week), elected officials of governmental units participating in the Plan. Retired employees who were participating in the Plan on the day before their retirement date and who meet the age and/or years of service requirements for retirement from the Florida Retirement System

are eligible for enrollment in the Plan.

1.01.02 DEPENDENT COVERAGE

Dependents of Eligible Employees are eligible for enrollment in the Plan.

Dependents are:

(1) the wife or husband of an Eligible Employee.

(2) any child of an Eligible Employee who is under the age of 26. Coverage will end on the last day of the month in which the child turns age 26, unless the child meets the additional eligibility requirements of items 3 or 4 below. Coverage will end on the last day of the month in which the child turns 18 if under Legal Guardianship.

(3) A child of an Eligible Employee who is age 26 to 30, who is (a) unmarried, (b) does not have a dependent of his or her own, (c) is a resident of Florida or a full-time or part-time student, and (d) is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act. Such a child may be covered until the end of the calendar year in which he or she reaches age 30.

(4) A child of any age of an Eligible Employee who, prior to becoming ineligible as a Dependent under the Plan, becomes incapacitated by reason of physical or mental disability as long as the child remains incapacitated, the child is not capable of self-support, and the child depends mainly on the Employee for support. The Employee must provide Employer proof that the child meets these conditions upon request.

Child includes the following:

- A natural born child.
- A stepchild.
- A legally adopted child. A child is considered legally adopted on the date of placement for adoption.
- A child up to the age of 18 months living in the home of an Eligible employee and born to a covered dependent child.
- A foster child or a child for whom the Employee or spouse has legal custody or guardianship

Verification of Student Status

For purposes of dependent coverage based in whole or in part on student status, the student must provide to the Plan Administrator the School's Letter of Attendance signed by the Student and the School's Authorized Representative within 60 days of the beginning of the Fall and Winter/Spring Semesters.

Eligibility for Continued Coverage for Students on Medically Necessary Leaves of Absence

A federal law called "Michelle's Law" provides continued coverage for children who are covered under the Plan based on their student status but lose their student status because they take a medically necessary leave of absence from school.

As a result, if your child is no longer a student, as defined in the plan, because he/she is on a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the Plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

1. begins while the child is suffering from a serious illness or injury,

2. is medically necessary, and
3. causes the child to lose student status for purposes of coverage under the Plan.

The coverage provided to children during any period of continued coverage:

1. is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
2. stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the Plan is changed during this one-year period, the Plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the Plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the Plan within a 90 day timeframe stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Qualified Medical Child Support Order

An Employee is required by a qualified medical child support order as defined in the Omnibus Budget Reconciliation Act of 1993 to provide coverage for the Employee's children, these children can be enrolled as timely enrollees "as required by the Act if otherwise eligible under the Plan".

If the Employee is not already enrolled, the Employee may also enroll as a timely enrollee at the same time.

Special Provision for Newborn Children

If a newborn is enrolled on, prior to, or within 60 days of the newborn's date of birth, dependent coverage is effective on the newborn's date of birth. If notice is given within 30 days after the birth, premium will not be billed until the first of the month following the date the child was born. If notice is not given within the 30 day period referenced above, the applicable premium will be charged from the date of birth.

If notice is given within 60 days of the birth of the child, the Plan may not deny coverage for the child due to the failure of the Covered Person to timely notify the Plan of the birth of the child. If notice is not given within the 60 day period, you must wait until the next open enrollment period to enroll the child.

1.01.03 PROOF OF ELIGIBILITY

An Employee must complete the dependent enrollment template and upload the required documents in the Benefit Administration system.

1.01.04 PROOF OF LEGAL RELATIONSHIP

Employees are required to provide proof of Dependents' eligibility including but not limited to birth certificates, marriage licenses, Orders of a court of competent jurisdiction authorizing custody or guardianship or such other documents as reasonably necessary to establish Dependent eligibility to the Plan Sponsor prior to the Effective Date of Coverage. Eligible newborns are added at time of birth.

1.02 WAIVER OF COVERAGE

1.02.01 WAIVER OF EMPLOYEE COVERAGE

If you waive your medical coverage during initial eligibility and then wish to apply at a later date, you may only enroll during an Open Enrollment Period or a Special Enrollment Period due to a family status change. According to guidelines set forth by the Affordable Care Act, the YourChoice Health Plan does provide minimum essential coverage and the health coverage meets the minimum value standard for the benefits it provides; therefore, if an Eligible Employee waives coverage, that employee will not be eligible for a federal subsidy for individual coverage.

1.02.02 WAIVER OF DEPENDENT(S) COVERAGE

If you waive coverage for dependents and then apply for coverage at a later date, you may only apply during an Open Enrollment Period or a Special Enrollment Period with evidence of insurability.

1.02.03 MONETARY REIMBURSEMENT

There is no monetary reimbursement for Waiver of Coverage.

1.03 RETIREE COVERAGE

Retiree Medical Benefits are not guaranteed to an Employee hired after January 2006.

Eligible Retirees

A full-time Employee who is eligible for Retirement Benefits as defined by Florida Law from the Florida Retirement System (FRS) is eligible to continue to participate in the Plan under the following conditions.

- An Employee must be enrolled in the Plan on the last day of work. An Employee's eligible Dependent(s) can be added when the employee retires, as a result of a status change (see section 1.05) or can be added at open enrollment.

- An Employee must elect to receive FRS Benefits immediately in order to continue to participate as a retiree under the following guidelines:

Pension Plan: The Retiree has met the age and/or service requirements as defined by the Florida Retirement System (FRS), is vested in the FRS Pension Plan as determined by FRS and is leaving the County service to receive normal, early or disability retirement benefits.

Investment Plan: The Retiree is vested in the FRS Investment Plan and is leaving the County service and either meets the age and/or years of service requirements to qualify for Normal Retirement (as defined by Pension Plan rules), OR meets the required number of creditable services years to be vested (as defined by Pension Plan) and is age 59 ½ {as determined by the Internal Revenue Code (72(t)(2)(A)(i)}. Employees enrolled in the Investment Plan who are over age 59 ½ but are not vested as determined by FRS Pension Plan Guidelines are not eligible for retiree medical benefits.

FRS Normal Retirement Guidelines:

Regular Class members will be eligible as follows:
Enrolled in FRS prior to 7/1/2011:
o Age 62 with at least 6 years; or
o 30 years of service, regardless of age; or
Enrolled in FRS on or after 7/1/2011:
o Age 65 with at least 8 years of service; or
o 33 years of service, regardless of age.

Special Risk Class members will be eligible as follows:
Enrolled in FRS prior to 7/1/2011:
o Age 55 with at least 6 years of service; or,
o 25 years of Special Risk Service, regardless of age; or
o Age 52 and have 25 years of Special Risk Service and military service.
Enrolled in FRS on or after 7/1/2011:
o Age 60 with at least 8 years of Special Risk service; or
o 30 years of Special Risk service, regardless of age; or
o Age 57 and have 30 years of Special Risk service and military service.

1.03.01 ELIGIBLE RETIREE ENROLLMENT

Eligible Retired Employees must enroll themselves and their eligible dependents in the Plan within 30 days after the effective date of the Retiree's retirement and pay a premium. In an effort to reduce possible gap in coverage, the retiree should begin the enrollment process 30 days prior to the last day of employment.

Eligible Retired Employees must complete a Manatee County Government Manatee YourChoice Enrollment Application or a Transamerica Supplement plan application and provide Proof of Eligibility to receive FRS Benefits at the time of enrollment

Notwithstanding the above, any former employee enrolled in the County's health benefits plan as of December 31, 1999, except those covered under COBRA provisions may continue his/her benefits as long as premium payments are made according to the Plan Documents.

1.03.02 SURVIVING SPOUSES OF ELIGIBLE RETIREES

Upon the death of an Eligible Retiree, a Surviving Spouse, who is then enrolled as an Eligible Dependent, may remain eligible for coverage under the Plan, as long as the spouse is not enrolled in any other similar plan **(except Medicare**). If the spouse is enrolled in any other plan, he or she will no longer be eligible under this Plan.

1.03.03 RETIREE PREMIUM ASSISTANCE

A Retired Employee who has been employed by a participating employer or combination of participating employers for at least 10 years prior to receiving benefits from the Florida Retirement System may be eligible for Premium Assistance approved annually by Board of County Commissioners.

1.03.04 REINSTATEMENT AFTER TEMPORARY SUSPENSION OF RETIREE'S ENROLLMENT

Retirees are allowed to suspend their retiree medical benefits for the purposes of enrolling in the County's self-funded plan as a full time active employee or a dependent of another County employee and can return to the retiree health plan options upon termination as an active employee/dependent as long as there is no break in coverage. Only Retirees with a retirement effective date of 12/31/2013 and prior had the opportunity to suspend Retiree Medical/Dental coverage if eligible for benefits under a new employer's Group Medical/Dental Plan. The rules for suspending retiree benefits coverage for this group of retirees are as follows:

- Retiree provides appropriate proof of coverage and termination of coverage by the new employer; and
- the temporary suspension due to the availability of other insurance will be allowed only one time after retirement; and
- the Retiree has 30 days from termination of previous coverage to enroll in the County sponsored retiree health plan options

1.03.05 NO REINSTATEMENT EXCEPT AS OTHERWISE PROVIDED

Except as provided in Section 1.03.04, no Retiree or Dependent Retiree who terminates benefits is permitted to re-enroll in the Plan.

1.04 CHANGES IN COVERAGE - FAMILY STATUS CHANGE

You are permitted to make changes in your elections for coverage in the event of the following family status changes:

If the cost of coverage increases or decreases during the Plan Year in an insignificant amount, corresponding changes consistent with such increase or decrease will automatically be made to your election under this Plan.

Any other change in election may be made only if the change is both because of and consistent with significant cost increases, significant cost decreases, significant changes in coverage or Changes in Status as provided below.

- Significant Cost Increases or Decreases. If during a Plan Year, there is a significant increase in the cost of coverage you may either increase your election under the plan to pay for the increase, or terminate coverage, or, if available, elect coverage under another plan offering similar coverage. If there is a significant decrease in the cost of coverage, you may elect to begin coverage if you have not done so

already. However, you may not change your elections under the Health Care Spending Account.

- Changes in Participant's Coverage. If your coverage is significantly curtailed or ceases during a Plan Year, and similar coverage is available under another option, you may terminate coverage under the Plan and elect coverage under the other option. Coverage under the Plan is significantly curtailed only if there is an overall reduction in coverage that constitutes reduced coverage to participants generally. If a benefit option is added under the Plan during any Plan Year, you may change your election to elect the new benefit option. However, you may not change your elections under the Health Care Spending Account.

- Changes in Spouse or Dependent's Coverage. You may change your election if there is a change in coverage offered under the plan of your spouse's or dependent's employer (the "Other Plan") and (1) the Other Plan permits participants to make an election change that would be permitted under this Plan or (2) the Other Plan has a different period of coverage than this Plan and your spouse or dependent makes an election change during the Other Plan's open enrollment period. However, you may not change your elections under the Health Care Spending Account.

- Certain Changes in Status. The following items are each a "Change in Status":

    - A change in the legal marital status of the participant, including marriage, divorce, death of spouse, legal separation or annulment;

    - A change in the number of dependents (as determined with respect to a particular benefit option), including birth, adoption, placement for adoption, or the death of the participant's dependent;

    - An employment status change of the participant, spouse or dependent, including termination or commencement of employment, switch between part-time and full-time employment, a strike or lockout, commencement of or return from an unpaid leave of absence, change in the worksite, or change in job classification impacting eligibility under this Plan;

    - The participant's dependent satisfies or ceases to satisfy the requirements for dependents because of age, student status or similar circumstances;

    - A special enrollment period as required by law;

    - Entitlement to (or loss of) Medicare or Medicaid;

    - Receipt of a qualified medical child support order or other court order which affects a dependent child's coverage; and

    - Such other events that the Plan Administrator determines will permit a change or revocation during a Plan Year under regulations and rulings of the Internal Revenue Service.

Family Status Changes must meet the following provisions per IRS Section 125:

- Consistency. Changes in elections which are permitted by subsection (1.05) above must be consistent with the Change in Status. Election changes are generally deemed consistent with the Change in Status only if made on account of and corresponding with a Change in Status affecting eligibility for coverage under an employer's plan.

- Change in Status Notification. Each Participant must complete a new Medical and/or Dental Application(s) form within thirty-one (31) days (60 days for newborn) from the date of the Change in Status. Payment of any Eligible Expenses under the Plan incurred after the thirty-one (31) days will not be paid unless the application was completed prior to the incurred date.

- Approval of Change. The Plan Administrator must approve any change in election resulting from a Change in Status, including satisfaction of the consistency requirement. The Plan Administrator may request and receive any documents the Plan Administrator deems necessary to substantiate a Change in Status. Such documents may include, without limitation, a marriage certificate, divorce decree, birth certificate, confirming letter from spouse's former employer, or any other relevant document. All such

documents shall be provided at the participant's expense, if any.

1.04.01 CLASS CHANGES

If your Coverage Class changes, the Coverage provided by your new class will take effect on the first day of the month on or next following the date of the change.

1.04.02 AGE CHANGES

If Coverage terminates because you reach a stated age, this change will take effect on the first day of the month next following the date on which you reached that age.

1.05 TERMINATION OF COVERAGE

Your Coverage will automatically terminate on the earliest of:

1. the date this Plan terminates; OR
2. the last day for which your contribution has been paid; OR
3. the date you enter into full-time military, naval, or air service; OR
4. the date you are no longer a Full-Time Employee; OR
5. the last day of the month following termination of employment.

Except that if you are no longer working for one of the reasons shown below. The Plan Sponsor may continue your Coverage by making the contributions for the period of time shown:

1. Leave of Absence under Family Medical Leave Act in accordance with FMLA requirements
2. Authorized Leave of Absence for six months.

Continuation of Coverage, as described, must be based on a plan which precludes individual selection by the Plan Sponsor.

1.05.01 DEPENDENT COVERAGE TERMINATION

Dependent Coverage for each of your Eligible Dependents will automatically terminate on:

1. the last day for which your Dependent's contribution has been paid; OR
2. the date he or she is no longer a Dependent as defined in Section 1.01.02 of this Plan OR
3. the date your employee coverage terminates.
4. For the child of a dependent, the date the Dependent's coverage terminates or eighteen months (18) of age, whichever comes first.

No benefit payment shall be made for charges incurred after the date this Plan is terminated except as provided in any extended benefits provision of this Plan.

SECTION 2 - PLAN GUIDELINES

2.00 SCHEDULE OF BENEFITS

2.01 PLAN DESIGN

Medical Benefits

This Plan pays for Covered Services and Supplies received from Network providers and Non-Network Providers. A directory of the Network Providers is available on line at www.manateeyourchoice.com.

The Plan provides reimbursement for Covered Services and Supplies at two levels:

- Covered Services and Supplies provided to a Covered Person by In Network Providers will be reimbursed at a premium level of reimbursement as described in the Schedule of Benefits.

- All other Covered Services and Supplies provided to a Covered Person by Out of Network Providers will be reimbursed at a reduced level of reimbursement and/or higher level of Covered Person's responsibility for payment as described in the Schedule of Benefits.

The Network fee is the level of reimbursement the Aetna providers have agreed to accept for covered services and supplies less the co-payment, deductibles and co-insurance listed in the schedule of benefits. Covered persons are not liable for any difference between the reasonable and customary charge and the contracted rates for those covered services and supplies.

Covered Services and Supplies provided outside of the Network are reimbursed at a Reasonable and Customary fee for the area where the services are performed. The Covered Person is responsible to the Provider for the difference between the amount reimbursed by the Plan and the billed amount if obtaining services from a Non-Par Facility*

*Network Facilities contract with Hospital-based providers (ER Physicians, Anesthesiologists; Radiologists, Pathologists) that at times are not contracted with the Network. In these situations, the Non-Network Provider is reimbursed at a Reasonable and Customary fee less the co-payment, deductibles and co-insurance listed in the schedule of benefit; the Covered Person is not liable for any difference between the reasonable and customary fee and the billed charge for those covered services and supplies.

Co-payments

Before Medical Benefits are payable, each Covered Person must satisfy certain Co-payments.

A Co-payment is the amount a Covered Person must pay to a Provider at the time covered services and supplies are given. Co-payments are not counted toward Deductible or Out-of-Pocket requirements. The amount of each Co-payment is shown in the Schedule of Benefits.

Out-of-Pocket Expenses

Covered Expenses are payable at the percentage shown in the Schedule of Benefits until any Out-of-Pocket Maximum shown in the Schedule of Benefits has been reached during a Calendar Year after Deductible. Then, covered Expenses are payable as shown.

Only Covered Expenses that the Covered Person pays count toward the Out-of-Pocket Maximums.

Deductibles

Deductibles are the fixed dollar amounts as described in the Schedule of Benefits a Covered Person must pay before the Plan will pay for Covered Services.

Co-Insurance

Co-Insurance is the percentage of the cost of a Covered Service as described in the Schedule of Benefits a Covered Person must pay after the Deductible has been satisfied.

2.02 OUT-OF-AREA VACATION OR BUSINESS

A Covered Person traveling out-of-area while on vacation or County business who requires Covered Services or Supplies will be reimbursed at the highest level of their enrolled Plan at time of service. To be eligible for Coverage, Emergency Medical Care must be provided as soon after the onset as possible, but no later than 24 hours after the onset, of a medical condition for which a Covered Person seeks Emergency Medical Care.

2.03 PRE-CERTIFICATION FOR HOSPITALIZATION

Your Provider, if in Network, is responsible for pre-certifying your stay by contacting the Utilization Management Department within seven (7) working days prior to a scheduled, non-emergency admission; or, within 24 hours (or next working day) following an Emergency Admission.

2.04 YOURCHOICE HEALTH PLAN

Effective January 1, 2006, the Plan Document was amended to provide participants the choice to upgrade their individual health plan level beyond the base plan offering by choosing one of four benefit levels based upon completing specific evidence-based care. The County Administrator is authorized to establish the Guidelines and Rules, Levels of Reimbursement and Qualifying Events for the *Your Choice* Health Plans.

2.04.01 YOURCHOICE PLAN DESIGN

The *YourChoice* Health Plan Levels are:

- *Your Choice* Basic — Lowest Level of Reimbursement
- *Your Choice* Better — Middle Level of Reimbursement
- *Your Choice* Best — Higher Level of Reimbursement
- *Your Choice* Ultimate — Highest Level of Reimbursement

The four Plans have:

- Identical Medical, Prescription, and Behavioral Health benefits
- Choice to utilize the Network or Non-Network providers,
- Choice to utilize or not to utilize Manatee YourChoice Qualifying Guidelines, and
- Choice to utilize the Health Management and Wellness Programs.
- Identical premiums and premium cost sharing

2.04.02 *YOURCHOICE* SUBSCRIBERS

Each plan member (Employee, Retiree, Covered Spouse, Covered Dependent) is enrolled in their own, unique YourChoice Health Plan level depending upon the completion of the Plan's Qualifying Events.

2.04.03 *YOURCHOICE* QUALIFYING EVENTS

A Qualifying Event is a specific course of action to be chosen and completed by a Member to determine which Your Choice Health Plan the Member is enrolled in for the subsequent Plan Year. The qualifying events are based on Evidence Based Preventative Care Guidelines and may be adjusted annually. Refer to the document on the website titled, "Qualifying Event Guidelines", approved annually by the County Administrator, for detail.

Members enrolled in the medical plan for primary and secondary coverage, with the exception of retired employees over age 65, are required to complete Qualifying Events to access plans other than the Basic Plan.

The Qualifying Events that require a copayment are indicated; adjustments are determined by the Plan Manager and approved by the Plan Administrator.

2.05 SCHEDULE OF BENEFITS

Schedule of Benefits for the *Your Choice* Health Plans are approved by the Board of County Commissioners and may be found in Section 3 of the Plan Document.

2.06 RESOLUTION R-98-82

The Board of County Commissioners adopted Resolution R-98-82 authorizing the County Administrator, or his Designee, to execute amendments to insurance agreements to conform to Federal Law and State Statutes, Plan Design Changes and Premiums.

2.07 EMPLOYEE/RETIREE OTHER INSURANCE

An active Employee enrolled in the County's plan is primary and any other plan is Secondary, including enrollment in Medicare or Medicaid. Any Dependent enrolled in their own employer plan is primary and the YourChoice Plan is secondary. Enrolled Dependents of Active Employees who also have Medicare/Medicaid are primary with the YourChoice Plan. Any retired member or their dependent eligible for Medicare Part A and B benefits must enroll in Medicare prior to their 65th birthday or upon eligibility in order to receive any benefits under the medical plan or the supplemental plans. This includes members eligible due to End Stage Renal Disease, members under 65 on disability and retirees age 65 and older. Medicare is the primary insurer for those Retirees and Spouses age 65 and over or employees/retirees under 65 enrolled in Medicare disability and employees with end stage renal disease after the coordination period.

2.08 NEW EMPLOYEE ENROLLMENT

Upon election of coverage, all New Employees and Eligible Dependent(s) (Spouse and Children age 19 and over) are initially enrolled in the Ultimate or Best Health Plan following the benefits waiting period. Enrollees will remain in the initial plan level until the next Qualifying Event period and annually thereafter, where they will have the option to choose other plan levels based on their completion of evidence based preventative care.

All New Employee's Covered Dependent Child(ren) under age 19
Upon election of coverage, all new dependent Child(ren) under age 19 will be initially enrolled in the Ultimate Health Plan. Enrollees will remain in the initial plan level until the next Qualifying Event period, and annually thereafter, where they will have the option to choose other plan levels based on their completion of evidence based preventative care.

2.09 FAMILY STATUS CHANGE

An Employee adding eligible adult dependent(s) through a Family Status Change is/are eligible to qualify for the Ultimate or Best Health Plan following the benefits waiting period. Enrollees will remain in the initial plan level until the next Qualifying Event period, and annually thereafter, where they will have the option to choose other plan levels based on their completion of evidence based preventative care.

2.09.01 NEW BORN BABY

An employee's first newborn baby will be automatically enrolled in the Ultimate Plan upon request for coverage. The added newborn is required to re-qualify during the next Qualifying Event Period and annually thereafter.

SECTION 3 - SCHEDULE OF BENEFITS

3.00 COMPREHENSIVE MEDICAL BENEFITS AND EXPENSES FOR ALL COVERED PERSONS

Note: The maximums listed below are the total for in-network and out-of-network expenses

NETWORK PROVIDERS **Costs represent member responsibility**	**ULTIMATE PLAN**	**BEST PLAN**	**BETTER PLAN**	**BASIC PLAN**
Preventive & Wellness Exams				
Adult Annual Physical Exam & Immunizations	No Co-pay	No Co-pay	No Co-pay	No Co-pay
Child Annual Exam & Immunizations	No Co-pay	NA	No Co-pay	NA
Child Preventive Dental Program - Prophylaxis, Radiology, Restorative	No Co-pay	NA	No Co-pay	NA
Hospital Benefits –Inpatient ***(Pre-Cert Required)(Facility Charges)***				
Deductible per Confinement*	None	$250	$250	$1,000
Coinsurance per Confinement	None	20% up to $1,000 OOP	25% up to $1,200 OOP	50% up to $3,000 OOP
Maximum Out of Pocket Expense per Confinement **after Deductible**	$0	$1,000	$1,200	$3,000
*Hospital Deductible only applies to the facility charges all other charges fall to the Medical Benefit Deductible				
Physician/Medical Benefits **(All Expenses other than Inpatient Facility)**	**ULTIMATE PLAN**	**BEST PLAN**	**BETTER PLAN**	**BASIC PLAN**
Deductible	None	$250	$500	$1,000
Coinsurance (after Deductible)	None	20% after Deductible	25% after Deductible	50% after Deductible
Annual Individual Out-of-Pocket (after Copay & Deductible	$1,400	$1,800	$2,400	$5,000
	ULTIMATE PLAN	**BEST PLAN**	**BETTER PLAN**	**BASIC PLAN**
Emergency Room				
Copay*	$100 per Visit	$150 per Visit	$200 per Visit	$300 per Visit
Coinsurance*	None	20% after Deductible**	25% after Deductible**	50% after Deductible**
*ER Copay, Deductible, and Coinsurance waived if admitted to Inpatient level of care **Deductible amount is the Plan Physician/Medical Benefit Deductible				

	ULTIMATE PLAN	BEST PLAN	BETTER PLAN	BASIC PLAN
Allergy Testing / Treatment				
Allergy Testing	$25.00 copay	20% after Deductible	25% after Deductible	50% after Deductible
Allergy Treatment (including serum)- Adult	100% covered	20% after Deductible	25% after Deductible	50% after Deductible
Allergy Treatment (including serum) - Child	100% covered	NA	25% after Deductible	N/A
Ambulatory Surgery Center (Pre-Cert may be required)				
Copay/Deductible/Coinsurance	100% Covered	20% after Deductible	25% after Deductible	50% after Deductible
Ancillary Services: Lab, Radiology (X-Ray), MRI, CAT Scans, Ambulance Services Emergency Air Transport to the nearest hospital that can provide the appropriate treatment for the Emergency condition (Pre-Cert may be required)				
Copay/Deductible/Coinsurance	100% Covered	20% after Deductible	25% after Deductible	50% after Deductible
OB / GYN - Maternity *(Pre-Cert Required)*				
Copay per Office Visit	$100 per Initial visit per pregnancy	None	None	None
Coinsurance After Deductible	None	20% after Deductible	25% after Deductible	50% after Deductible
Primary Care and Specialty Physicians				
Copay per Office Visit	$25	$25	None	None
Coinsurance After Deductible	None	20% after Deductible	25% after Deductible	50% after Deductible
Telemedicine				
Copay / Deductible/ Coinsurance	$25	$25	25% after Deductible	50% after Deductible
Urgent Care				
Copay / Deductible / Coinsurance	$25 Co-pay per Visit	20% after Deductible	25% after Deductible	50% after Deductible

	ULTIMATE PLAN	BEST PLAN	BETTER PLAN	BASIC PLAN
Alternate Care Benefit				
Copay / Deductible / Coinsurance. Each benefit has a separate maximum number of allowed visits per plan year.				
Chiropractic (including Spinal Manipulation)				
Copay/Coinsurance	$25.00 per visit	20% after Deductible	25% after Deductible	50% after Deductible
Maximum Allowed Visits per year	20 visits	20 visits	20 visits	20 visits
Nutritional Therapy - Registered Dietitian				
Copay / Coinsurance	$0-visits 1-5 $25/visit beyond	$0-visits 1-5 $25/visit beyond	$0-visits 1-5 $25/visit beyond	$0-visits 1-5 $25/visit beyond
Maximum Allowed Visits per year	20 visits	20 visits	20 visits	20 visits
Occupational Therapy				
Copay/Coinsurance	$25.00 per visit	20% after Deductible	25% after Deductible	50% after Deductible
Occupational Therapy at a free-standing facility: Maximum Allowed Visits per year	20 visits	20 visits	20 visits	20 visits
Occupational Therapy at a Hospital-based facility: Maximum Allowed Visits per year	5 visits	5 visits	5 visits	5 visits
Physical Therapy				
Copay/Coinsurance	$0-visits 1-5 $25/visit beyond	20% after Deductible	25% after Deductible	50% after Deductible
Physical Therapy at a free-standing facility: Maximum Allowed Visits per year	20 visits	20 visits	20 visits	20 visits
Physical Therapy at a Hospital-based facility: Maximum Allowed Visits per year	5 visits	5 visits	5 visits	5 visits
Speech Therapy				
Copay/Coinsurance	$25.00 per visit	20% after Deductible	25% after Deductible	50% after Deductible
Maximum Allowed Visits per year-free standing	20 visits	20 visits	20 visits	20 visits
Maximum Allowed Visits per year-Hospital	5 visits	5 visits	5 visits	5 visits
Acupuncture				
Copay/Coinsurance	$25.00 per visit	20% after Deductible	25% after Deductible	50% after Deductible
Maximum Allowed Visits	20 visits	20 visits	20 visits	20 visits

	ULTIMATE PLAN	BEST PLAN	BETTER PLAN	BASIC PLAN
Massage Therapy				
Copay/Coinsurance	$25.00 per visit	20% after Deductible	25% after Deductible	50% after Deductible
Maximum Allowed Visits	20 visits	20 visits	20 visits	20 visits
DME *(Pre-Cert Required if over $1500)*				
Rental, Repair and Purchase	10% Coinsurance	20% after Deductible	25% after Deductible	50% after Deductible
Orthotics				
Coinsurance *(Pre-Cert Required if over $1500 and always required for Oral-Sleep Apnea appliances)*	10% Coinsurance	20% after Deductible	25% after Deductible	50% after Deductible
Surgical Supplies				
Coinsurance	10% Coinsurance	20% after Deductible	25% after Deductible	50% after Deductible
Home Health *(Pre-Cert Required)*				
Maximum Benefit - Annual	120 Days	120 Days	120 Days	120 Days
Coinsurance	None /100% Covered	20% after Deductible	25% after Deductible	50% after Deductible
Hospice - Licensed Facility *(Pre-Cert Required)*				
Inpatient/Outpatient Care	100% Covered	100% Covered	100% Covered	100% Covered
Rehabilitation Out Patient Facility *(Pre-Cert Required)*				
Coinsurance	None /100% Covered	20% after Deductible	25% after Deductible	50% after Deductible
Skilled Nursing and/or Acute Rehabilitation Facility *(Pre-Cert Required)*				
Maximum Benefit - Annual	60 Days	60 Days	60 Days	60 Days
First 10 Days	100%	100%	$200 per day	$200 per day
Day 11 to 60 Day	10% coinsurance	20% after Deductible	25% after Deductible	50% after Deductible
Eye Exams-Medical Plan				
Routine Eye Exam*-Adult and Children 1 per year for glasses or contact lenses	$25 copay for Exam Only	20% after Deductible	25% after Deductible	50% after Deductible
Routine Eye Exam (Diabetic) - 1 per year	No Co-pay	No Co-pay	No Co-pay	No Co-pay
Eye Exams- Medical Condition	$25 Copay for Exam Only	20% after Deductible	25% after Deductible	50% after Deductible
Glasses following Cataract Surgery	100% Covered	20% after Deductible	25% after Deductible	50% after Deductible
Refraction is a covered expense. Contact lens fitting is not a covered expense.				

OUT OF NETWORK BENEFITS*	ULTIMATE PLAN	BEST PLAN	BETTER PLAN	BASIC PLAN
Preventive & Wellness Exams				
Adult Annual Physical Exam & Immunizations	Ded and Coins.	Ded and Coins.	Ded and Coins.	Ded and Coins.
Child Annual Exam & Immunizations	Ded and Coins.	Ded and Coins.	Ded and Coins.	Ded and Coins.
Child Preventive Dental Program - Prophylaxis, Radiology, Restorative*	100% covered up to OON rate	100% covered up to OON rate	100% covered up to OON Rate	100% covered up to OON rate
*Members may be responsible for charges above the established fee schedule when using an OON Dentist				
Hospital Benefits -Inpatient ***(Pre-Cert Required)(Facility charges)***				
Deductible* per Confinement	$250	$750	$1,000	$2,000
Coinsurance per Confinement	20%	20%	25%	50%
Max. OOP per Confinement (**after deductible**)	$2,550	$2,450	$2,600	$3,000
OOP=Out of Pocket				
*Hospital Deductible only applies to the facility charges all other charges fall to the Medical Benefit Deductible				
Physician /Medical Benefits **(All Expenses other than Inpatient Facility)**				
Deductible	$500	$750	$1,000	$2,000
Coinsurance (after Deductible)	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Annual Individual Out-of-Pocket (**after** Deductible)	$2800	$5000	$7200	$10,000
Emergency Room				
Copay*	$100 per Visit	$150 per Visit	$200 per Visit	$300 per Visit
Coinsurance*	None	20% after Deductible **	25% after Deductible**	50% after Deductible**
*ER Copay, Deductible, and Coinsurance waived if admitted to Inpatient level of care. **Deductible amount is the Plan Physician/Medical Benefit Deductible				
Allergy Testing / Treatment				
Allergy Testing	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Allergy Treatment (including serum)- Adult	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Allergy Treatment (including serum) - Child	20% after Deductible	NA	25% after Deductible	N/A
Ambulatory Surgery Center ***(Pre-Cert may be Required)***				
Deductible/Coinsurance	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible

	ULTIMATE PLAN	BEST PLAN	BETTER PLAN	BASIC PLAN
Ancillary Services-Laboratory, Radiology (X-Ray), MRI, CAT Scans, Ambulance Services, Emergency Air Transport to the nearest hospital that can provide the appropriate treatment for the Emergency Condition. (Pre-Cert may be Required)				
Deductible/Coinsurance	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
OB / GYN - Maternity *(Pre-Cert Required)*				
Deductible/Coinsurance	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Primary Care / Specialty Physicians				
Deductible/Coinsurance	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Urgent Care				
Deductible/Coinsurance	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Alternate Care Benefit				
Each benefit has a separate maximum number of allowed visits per plan year.				
Chiropractic (including Spinal Manipulation)				
Deductible/Coinsurance	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Maximum Allowed Visits per year	20 visits	20 visits	20 visits	20 visits
Nutritional Therapy - Registered Dietitian	Not Covered	Not Covered	Not Covered	Not Covered
Occupational Therapy				
Coinsurance	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Occupational Therapy-Free Standing Provider: Maximum Allowed Visits per year	20 visits	20 visits	20 visits	20 visits
Occupational Therapy-Hospital based facility: Maximum Allowed Visits per year	5 visits	5 visits	5 visits	5 visits
Physical Therapy				
Coinsurance	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Physical Therapy at a free-standing facility: Maximum Allowed Visits per year	20 visits	20 visits	20 visits	20 visits
Physical Therapy at a Hospital-based facility: Maximum Allowed Visits per year	5 visits	5 visits	5 visits	5 visits

	ULTIMATE PLAN	BEST PLAN	BETTER PLAN	BASIC PLAN
Massage Therapy (Physician Ordered)				
Coinsurance	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Maximum Allowed Visits	20 visits	20 visits	20 visits	20 visits
Acupuncture				
	Not Covered	Not Covered	Not Covered	Not Covered
DME ***(Pre-Cert Required if over $1500)***				
Deductible/Coinsurance Rental, Repair and Purchase	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Orthotics ***(Pre-Cert Required if over $1500 and always required for Oral-Sleep Apnea appliances)***				
Deductible/Coinsurance	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Surgical Supplies				
Deductible/Coinsurance	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Home Health ***(Pre-Cert Required)***				
Maximum Benefit - Annual	120 Days	120 Days	120 Days or	120 Days
Deductible/Coinsurance	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Hospice - Licensed Facility ***(Pre-Cert Required)***				
Inpatient Care	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Rehabilitation Out Patient Facility ***(Pre-Cert Required)***				
Deductible/Coinsurance	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Skilled Nursing and/or Acute Rehabilitation Facility ***(Pre-Cert Required)***				
Maximum Annual Benefit	60 Days	60 Days	60 Days	60 Days
Day 1-20	$200 per day	$200 per day	$200 per day	$200 per day
Day 21 to 60	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Eye Exams				
Routine Eye Exam*-Adult and Children (glasses or contacts) - 1 per year	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Routine Eye Exam (Diabetic) - 1 per year	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Eye Exams- Medical Condition	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
Glasses following Cataract Surgery	20% after Deductible	20% after Deductible	25% after Deductible	50% after Deductible
****Refraction is a covered expense. Contact lens fitting fee is not a covered expense.***				

3.01 COVERED SERVICES AND SUPPLIES

Accident Related Dental Services

Services performed by a Doctor of Dental Surgery, "D.D.S.", or Doctor of Medical Dentistry, "D.M.D.", for the treatment of any sound natural teeth made necessary as a result of an Injury. Coverage is provided only when services are required as a result of an Injury (except for an Injury resulting from biting or chewing). No Coverage is provided unless the dentist certifies to Utilization Management, on behalf of the Plan Administrator, that teeth were sound natural teeth which were injured as a result of an accident. Services must be provided and completed within 6 months of the Injury and approved in advance by Utilization Management. (A sound natural tooth has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant, and functions normally in chewing and speech.) No Coverage is provided for dental implants.

Allergy Testing and Treatment

See Section 3 – Schedule of Benefits

Alternative/Holistic Therapy Services

Limited Services from Alternative and Holistic Health Providers for services including massage therapy and acupuncture, , from YourChoice Custom Providers or Providers with Direct contracts.

Ambulatory Surgical Center Services

Also known as outpatient surgery centers or same day surgery centers, are health care facilities where surgical procedures not requiring an overnight hospital stay are performed. Such surgery is commonly less complicated than that requiring hospitalization.

Anesthetics

A covered expense according to negotiated fees.

Assistant Surgeon Services

Covered Expenses for assistant surgeon services are limited based on the amount of Covered Expenses for the surgeon's charge for the surgery. An assistant surgeon must be licensed by the state in which the services are performed. An ARNP or a PA may be considered assistant surgeons.

Chemotherapy

Must be pre-certified by Utilization Management

Children’s Preventative Dental Services

Preventative Dental Services under the Medical Plan provided for children (under the age of 19) are diagnostic, radiographs, test and laboratory exams, preventive procedures.

- routine dental exams in a consecutive twelve (12) month period.
- 1 prophylaxis in any six (6) consecutive month periods
- 1 complete series or Panorex x-ray in any twenty-four (24) consecutive month period
- 1 extra-oral x-ray in any six (6) consecutive month periods
- Dental fillings

Cleft Palate and Cleft Lip Treatment for Children

Covered expenses for the treatment of cleft lip and cleft palate for a covered dependent under the age of 18. This coverage includes medical, dental, speech therapy, audiology, and nutrition services when prescribed by the treating health care practitioner. The health care practitioner must certify that such services are medically necessary and consequent to treatment of the cleft lip or palate.

Dental Anesthesia

General anesthesia for dental treatment or surgery when provided to (1) a Covered Person who is under 8 years of age who is determined by a licensed dentist and the child's physician to require necessary dental treatment in a hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proven to be ineffective; or (2) a Covered Person who has one or more medical conditions that would create significant or undue medical risk in the course of treatment delivery if not rendered in a hospital or ambulatory surgical center.

Diabetes Equipment and Training

Diabetes testing equipment and supplies as deemed medically necessary and appropriate by a physician; outpatient self-management training and educational services under the direct supervision of a certified diabetes educator, board-certified endocrinologist, or licensed dietitian.

Durable Medical Equipment

Durable Medical Equipment means equipment which meets all of the following:

- It is for repeated use and is a consumable item;
- It is used for a medical purpose and it is appropriate for use in the home.

Some examples of Durable Medical Equipment (DME) are:

Hospital beds, wheelchairs, walkers, oxygen, 3 in 1 commode, and orthopedic braces. Any device over $1500.00 requires precertification.

Medicare Guidelines are adhered to regarding Durable Medical Equipment.

End State Renal Disease

Members diagnosed with End Stage Renal Disease (ESRD) may become entitled to Medicare based on this condition. Benefits on the basis of ESRD are for all covered services, not only those related to the kidney failure condition. Medicare is secondary to your group health plan for individuals entitled to Medicare based on ESRD for a coordination period of 30 months.

Under this medical plan, members are provided coverage for end state renal disease (ESRD). ESRD is a medical condition covered by Medicare. While covered under this medical plan, Medicare will be the secondary payor for months 4 through 33 while members are receiving dialysis treatments. As of 11/1/2011, member's ESRD benefits will be covered and paid above the Medicare payment levels. Member's ESRD medical claims and drug related reimbursement will be repriced and paid at percentage of Medicare's reimbursement level. Medicare Law prohibits any provider from balance billing members for charges over these reimbursement amounts. Members with ESRD must notify the Health Plan Utilization Management when diagnosed with ESRD by a Physician, notify the Health Plan if or when they begin to receive dialysis treatments and enroll in Parts A&B of Medicare.

Home Health Care

The following Covered Services must be given by a Home Health Care Agency for any member with or without hospitalization following written certification that the services are medically indicated and the services are pursuant to a written treatment plan:

- Nursing Care visits performed by an RN or supervised by RN.

- Physical therapy. Occupational therapy. Speech Therapy or appropriate OTA or PTA, MSW Services.

Covered Services are limited to one (1) visit per day for a maximum of one hundred and twenty (120) visits each Calendar Year. Each period of home health aide care of up to four hours given in the same day counts as one visit. Each visit by any other member of the home health team will count as one visit.

Prior approval by Utilization Management is required for all Home Health Care Services.

Hospice Care

Services for the patient must be given in an inpatient Hospice facility, inpatient approved hospice facility, any other approved facility, or in the patient's home.

The Physician must certify that the patient is terminally ill with six (6) months or less to live.

Prior approval by Utilization Management is required for all Hospice Care.

Hospital Services

Room and Board. Covered Expenses for a private room are limited to the regular daily charge made by the Hospital for a semi-private room.

Other Services and Supplies.

Emergency Room.

When Emergency Care results in a confinement, the Network Provider must call Utilization Management for inpatient authorization on day one of the confinement. If the confinement occurs on a weekend or observed holiday, Utilization Management must be notified by the next business day.

Laboratory Tests and X-rays

X-rays or tests for diagnosis or treatment

Mammography

One annual mammogram for females age 40 and over.

One or more mammograms annually as recommended by a physician for any woman at risk for breast cancer because of personal or family history (i.e., mother, sister or daughter), a history of benign breast disease, or because she has not given birth by age 30.

Baseline and annual mammograms may be performed with or without a physician’s recommendation if the mammogram is obtained in an office, facility, or health testing service that uses radiological equipment registered with the Department of Health and Rehabilitative Services for breast cancer screening.

Medical Transportation Services

Transportation of patient only by professional ambulance, other than emergent air ambulance, to and from a medical facility with Utilization Management pre-approval.

Transportation of patient only by regularly-scheduled airline, or air ambulance, to the nearest medical facility qualified to give the required treatment with Utilization Management pre-approval.

These services must be provided within the United States.

Non-Accidental Dental Services

Charges for care and services performed for excision of tumors or benign bony growths, external excision and drainage of cellulitis, removal of bony impacted wisdom teeth, disorders of the temporomandibular joint (orthodontics, crowns, and inlays

are excluded). See Section 5.

Nurse-Practitioner Services

Services of a licensed or certified Nurse-Practitioner or Physician's Assistant acting within the scope of that license or certification is payable at the same level of the Physician allowable.

Outpatient Occupational Therapy

Services of a licensed occupational therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician to treat functional limitations in ADL activities of daily living.
- The therapy must be given in accordance with a written treatment plan to include instructions for home exercise regimen approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.
- The therapy is expected to result in significant, objective, measurable function improvement in the Covered Person's independence in ADL'S, within two (2) months of the start of the treatment.

Outpatient Physical Therapy

Services of a licensed physical therapist provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.
- The therapy is expected to result in significant, objective, measurable physical improvement in the Covered Person's condition, within two (2) months of the start of the treatment.

Outpatient Speech Therapy

Services of a licensed speech therapist.

These services must be given to restore speech lost or impaired due to one of the following:

- Surgery, radiation therapy or other treatment which affects the vocal cords.
- Cerebral thrombosis (stroke).
- Brain damage due to accidental injury or organic brain lesion (aphasia). Accidental injury.
- The therapy is expected to result in significant, objective, measurable physical improvement in the Covered Person's condition, within two (2) months of the start of the treatment.
- Services recommended by a child's school district as it relates to impaired speech are provided by the educational institution. Additional recommended services beyond what the educational institution provides are covered under the plan when medically necessary.

Physician Services

Medical Care and Treatment

Office and Home Visits

Consultations, Referrals

Second Surgical Opinions

Hospital Visits

Skilled Nursing Facility Visits

Emergency room services.

Surgery

Services for surgical procedures

Reconstructive Surgery

Reconstructive surgery is subject to precertification by Utilization Management. Cosmetic procedures are excluded from coverage

Prescribed Drugs and Medicines

Prescribed drugs and medicines. Precertification is required for certain medications.

Prosthetics and Orthotics

Prosthetic must be medically indicated and the result of illness or injury due to a covered condition and can replace lost body parts such as arm or leg.

Repair and/or replacement of orthotics will be reviewed by Utilization Management if over $1500.

Orthopedic shoes and shoe inserts are excluded, unless required for treatment of illness or injury due to a covered condition and approved by Utilization Management.

Radiation Therapy –Precertification required.

Skilled Nursing and/or Rehabilitation Therapy

Inpatient

- Services of a Hospital, Skilled Nursing or Rehabilitation Facility for room, board, care and treatment during a confinement with pre-approval are limited to the facility's regular daily charge for a semi-private room.
- Inpatient rehabilitative therapy is a Covered Service only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.
- Covered Services are limited to a combined total of sixty (60) days of confinement in a Hospital, Skilled Nursing Facility and/or Rehabilitation Facility each Calendar Year.
- Precertification required.

Outpatient

- Services of a Hospital Outpatient Rehabilitative Facility with pre-approval.
- Covered Services are limited to 20 days of therapy each Calendar Year. A day of therapy includes all services given by or visits to the facility in any 1 day.
- Covered Services for each day of therapy reduces the number of visits under Covered Services for Outpatient Physical Therapy, Outpatient Occupational Therapy or Speech Therapy. This reduction only applies to days of therapy during which the therapy includes services given by a physical therapist, occupational therapist or speech therapist.

Screening Exams

Age specific screenings as related to a medical condition or preventative care designed to prevent illness, disease or other health problems. Many of these services are covered as part of physical exams. These include regular checkups and routine gynecological and well-child exams. Preventative screening coverage follows the recommendations of national medical societies.

Second Surgical Opinion

When surgery is advised, a Covered Person may get a Second Opinion to confirm that surgery is needed. These opinions are subject to copays and coinsurance as applicable.

Vision Screening and Treatment under the medical plan

Vision Exam related to a medical condition.

Implanted lenses following cataract surgery.

Routine Eye Exam annually.

Routine Eye Exam (Diabetes Preventative)-annually

Refraction is a covered expense

Contact lens fitting fee is a non-covered expense under the medical plan

SECTION 4- HEALTH AND WELLBEING PROGRAM

The Plan's Incentive Program goals are to develop awareness and educational values through integrated programming for members of the plan while instituting accountability on the part of the member to live a healthier lifestyle.

To accomplish the goal in some incidence's incentives are made available to participants.
The incentive options are approved by the County Administrator on the recommendation of the Plan Administrator.

Rules and Guidelines of these programs can be found in a separate document titled "Qualifying Event Guidelines and Health and Lifestyle Management Incentive Program" at https://manateeyourchoice.com/ or from Employee Health Benefits.

SECTION 5- LIMITED COVERED EXPENSES

Program and charges listed in Section 5 are payable upon approval of Utilization Management according to Plan Guidelines. The Plan pays benefits based upon the *YourChoice* Health Plan the Member is enrolled in on the date of service.

5.00 TRANSPLANTS

Charges in connection with only the following transplants or replacement of tissue or organs to the extent they are not experimental are Covered Expenses and payable according to the Member's Plan Level (Basic, Better, Best, Ultimate) on date of service. Services must be pre-approved by Utilization Management.

Benefits are payable whether natural or artificial replacement materials or devices are used.

If both the donor and donee are covered under this Plan, the donor's and donee's charges are covered. If the donor is not covered under this Plan, but the donee is covered under this Plan, the donor's charges will be covered only to the extent that the donor's charges are not covered under any other plan (A notarized statement confirming coverage is required).

If the donor is covered under this Plan, and the donee is not covered under the Plan, the donor's charges and the donee's charges are not covered.

5.01 COSMETIC SURGERY LIMITATIONS

Charges in connection with COSMETIC SURGERY are covered only:

- as the result of an injury; and,
- for replacement of diseased tissue surgically removed.

5.02 SLEEP DISORDER BENEFITS

The Plan covers consultation and diagnostic testing for sleep apnea. Sleep disorder benefits are only paid when provided by a Network Specialty Provider (Sleep Disorder Specialists, Cardiology, Pulmonology, ENT and Neurology) Boarded in Sleep Disorders and pre-approved by Utilization Management. Benefits are paid in accordance with or based upon the participant's enrolled Plan Level on date of service.

CONSULTATION AND DIAGNOSTIC TESTING

The benefit includes one (1) Home sleep study (HST) within a 12 month period. Split night studies are only allowed for specific medical indications and must meet medical criteria. These are performed at a licensed facility." All studies require precertification.

LIMITATIONS CONSULTATIONS AND DIAGNOSTIC TESTING

A Network Provider must provide these services. No benefit will be paid to an Out of Network Provider.

FACILITY AND SURGEON EXPENSES

The Plan pays for surgical procedures and facility expenses by a Network Provider upon approval of Utilization Management. Prior to authorization for surgery attempts at conservative therapies must be tried to include weight reduction, if applicable. Physician documentation of failure is required.

5.03 TEMPOROMANDIBULAR DISORDERS (TMJ)

Services and expenses pertaining to the formulating of a diagnosis of Temporomandibular Disorders. The services include the office exam, and radiographic exams..

Oral appliances prescribed by treating Physician are subject to Utilization Management approval.

5.04 TEETH, GUMS, AND ALVEOLAR PROCESS

1) Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth.

2) Emergency repair due to injury to sound natural teeth.

3) Surgery needed to correct accidental injuries to the jaw, cheeks, lips, tongue, floor and roof of the mouth when the injuries occurred while covered under the Plan.

4) Excision of benign bony growths of the jaw and hard palate.

5) External incision and drainage of cellulitis.

6) Incision of sensory sinuses, salivary glands or ducts.

7) Removal of partial and fully impacted teeth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

5.05 NUTRITIONAL COUNSELING

Reimbursed only with Network Providers. See 3.00 Schedule of Benefits

5.06 BARIATRIC SURGERY

The Plan pays for Bariatric Surgery only according to Utilization Management guidelines and the program requirements outlined in the YourChoice guidelines for bariatric and pays benefits upon the YourChoice Health Plan level the Member is enrolled in on the date of service.

The Member requesting Bariatric Surgery must be pre-approved by Program Coordinator and Utilization Management that all the Guidelines are complete and utilize a Network provider. Panniculectomy after bariatric surgery is covered when all conditions of the utilization management criteria have been fully met. A lifetime limit of 1 procedure per member.

5.07 PAIN MANAGEMENT

DEFINITIONS:

Acute pain is defined as pain lasting for up to 3 months.
Chronic pain is defined as pain lasting greater than 3 months.

1. Pre-certification/Prior Approval for Injections and Procedures
    a. Pre-certification/prior approval is required for all pain management injections and other invasive procedures.

2. Prior Authorization for Pain Medications
    a. Prior authorization is required for selected oral pain medications
    b. Quantity and time limitations apply to selected pain medications as established by the contracted Pharmacy Benefit Manager's clinical guidelines.

5.08 GENETIC TESTING

Genetic testing must be pre-approved by Utilization Management. Any genetic testing is only for the direct care and treatment of the member/patient.

SECTION 6-UTILIZATION MANAGEMENT

6.00 UTILIZATION MANAGEMENT PROGRAM

The Utilization Management Program is a program administered by the Plan's Nurse Case Management Advocates. It provides Pre-admission review, Concurrent Review, and Discharge Planning on Hospital Admissions, Prescription, Case and Disease Management, Preventive Care and Wellness. Services are authorized in conjunction with Aetna Clinical Policy Bulletins and nationally recognized Milliman Criteria. Click HERE for the most up to date list of services requiring precertification.

6.01 SCHEDULED ADMISSIONS

When a Covered Person is Scheduled for Admission to any Hospital, notification of the need for certification must be received by Utilization Management prior to Hospital Admission. The responsibility of notifying Utilization Management lies with the Network Provider. Individuals are advised to contact the Utilization Management directly to verify that the admitting Physician or Hospital has made notification, particularly when Out of Network Providers are utilized. Members should be aware that some Physician services in the Network Hospitals may not be network providers and could face additional costs.

6.01.01 NON-SCHEDULED ADMISSIONS

When a Covered Person is admitted to any hospital on a Non-Scheduled basis, Utilization Management must be notified as soon as is reasonably possible if the admission is to an ICU service or on day one of the Hospital admission.

6.01.02 MATERNITY BENEFITS

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

Covered maternity services may, at the Covered Person’s election, be provided by a Certified Nurse-Midwife, a midwife licensed pursuant to Florida Statutes chapter 467, or an Alternative Birthing Center.

6.01.03 OTHER

For all other Covered Services requiring pre-certification, Utilization Management must be notified prior to receiving any of the Covered Services.

SECTION 7 - EXCLUSIONS AND LIMITATIONS

7.00 EXCLUSIONS AND LIMITATIONS

7.00.01 EXCLUSIONS

No benefits will be paid for:

1. Services or supplies for which a Covered Person is not required to pay or charges made only because Coverage exists (subject to the right, if any, of the United States to recover Reasonable and Customary Charges) for care provided in a military or veterans' hospital
2. A disease or injury for which benefits are paid or payable under Workers' Compensation or any Occupational Disease or similar law whether such benefits are insured or self-insured; or that is caused by, or connected in any way to, employment of the Covered Person. This includes self-employment or employment by others, whether Workers' Compensation or any Occupational Disease or similar law cover the charges incurred
3. Services or supplies received before a person was covered under this Plan or after coverage ceased under this Plan.
4. Services which were a result of complications, care or treatment required from treatment not covered under this Plan.
5. Charges due to motor vehicle accident injuries payable under Personal Injury Provision Protection/No-Fault Insurance Policy.
6. Health exams or tests that are not required for treatment of the disease or injury, except as specifically provided under Comprehensive Medical Benefits.
7. Injuries or illness due to war, or any act due to war, if declared or not.
8. Except as specifically provided under Covered Services and Supplies: eye glasses or the fitting of eye glasses; radial keratotomy; visual training; vision therapy, hearing aid or the fitting of hearing aids; shoes.
9. Educational testing or training.
10. Custodial Care.
11. Private Duty Nursing Care.
12. Sleep Disorders and the testing of Sleep Disorders except as specifically provided in the Plan
13. Plasmapheresis for the treatment except for accepted condition.
14. Charges incurred as a donor of an organ when the donor is not covered under this Plan.
15. Select Drugs and medicines may not be covered by the medical plan when the same drugs/medicines, are covered by the Pharmacy Benefit Plan.
16. Charges that are more than the Reasonable and Customary Charges or contracted rate for the services and supplies furnished.
17. Hospital services and supplies when confinement is solely for diagnostic testing purposes.
18. In vitro fertilization; infertility; embryo transfer procedures; artificial insemination; sex-change surgery; reversal of sterilization, penile implant.
19. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual re**a**ssignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
20. Care, treatment, services or supplies not prescribed by a Physician; or not medically indicated and/or evidence-based; or which are experimental as recognized in the United States, including clinical trials.
21. Services which are provided mainly for medical or other research.
22. Services which were received from a nurse, but which do not require the skill or training of a nurse.
23. Services which were payable under other provisions of this Plan
24. Services which were part of the Deductible or Co-payment provisions of this Plan; or which were received in a Hospital or Institution owned or operated by the United States Government or any of its agencies (subject to the right, if any, of the United States Government to recover Reasonable and Customary charges for care provided in a military or veterans hospital); or

25. Services which were provided or paid for by any governmental plan or law not restricted to the government's civilian employees and their dependents. (This will not apply to Medicaid); or
26. Services which were provided by any one of the following: (1) You; (2) your Dependent's; (3) you or your spouse's parents, child, sister, or brother; or (4) your Dependent's spouse, parent, child, sister, brother or a relative.
27. Charges for services received because of Injury or Sickness caused by or contributed to by engaging in a criminal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.
28. Nutritional Supplements (unless enrolled in a specific YourChoice Diabetes Care program).
29. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether prescribed by a Physician, except for wigs during chemotherapy.
30. Exercise programs for treatment of any conditions, except for Physician-supervised cardiac or pulmonary rehabilitation, occupational or physical therapy covered by this Plan.
31. Charges for services or supplies in connection with hearing aids or exams for their fitting unless required due to an accidental injury to the ear performed or sustained while the person is covered under this Plan. No charges are payable for treatment received more than six (6) months from the date of the surgery of the injury, unless otherwise stated in this Plan.
32. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
33. Treatment of hypnosis, except as part of the Physician's treatment of a mental illness or when hypnosis is used in lieu of an anesthetic.
34. Meridian Therapy (Acupuncture) unless performed by a Physician or licensed Acupuncturist.
35. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a non-business day. This does not apply if surgery is performed within 24 hours of admission.
36. Charges incurred for which the Plan has no legal obligation to pay.
37. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
38. Services, treatments and supplies which are not specified as covered under this Plan.
39. Care and treatment of obesity, weight loss or dietary control whether it is, in any case, a part of the treatment plan for another disease unless specifically covered under enrollment of the Plan's disease management program. Medically Indicated charges for Morbid Obesity will be covered.
40. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, , scales, elastic bandages or stockings, nonprescription drugs and medicines (except those covered under the Pharmacy benefit), and first-aid supplies, lift chairs, ramps, car lifts, and non-hospital adjustable beds.
41. Replacement of braces of the leg, arm, back, neck or artificial arms or legs, unless there is enough change in the Covered Person's physical condition to make the original device no longer functional as determined by the treating physician or licensed provider.
42. Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition, which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.
43. Care and treatment for reversal of surgical sterilization.
44. Care and treatment for tobacco cessation programs unless such care is specifically covered under enrollment of the Plan's disease management program.
45. Charges for travel or for travel outside the United States or its territories or accommodations, whether recommended by a Physician, except for ambulance charges as defined as a covered expense.
46. Care and treatment charges for Autologous Chondrocyte.
47. Complications resulting from the Covered Person's failure to substantially comply with the treatment plan

recommended by the Covered Person's Physician, including but not limited to a discharge from a Hospital or other facility against medical advice. Any otherwise covered charges incurred during an Inpatient Hospital or similar confinement may be excluded if the Covered Person is discharged against medical advice, even if such charges are incurred prior to such discharge.

48. Charges for failure to keep a scheduled visit or for the completion of forms.

7.01 DATE OF TERMINATION

No benefit payment shall be made for charges incurred after the date this Plan is terminated except as provided under any Extended Benefits Provisions of this Plan.

SECTION 8 -TREATMENT OF BEHAVIORAL HEALTH

8.00 BEHAVIORAL HEALTH

LAMP is the combined benefit of Employee Assistance Program and Managed Behavioral Health Benefit. It helps in addressing emotional, behavioral and addiction concerns. Services are designed to empower participants to make healthy changes that can result in an improved quality of life. Services are voluntary and confidential and case managed by providers under a third-party contract.

The *YourChoice* Health Plan provides separate Benefits for Plan Members requiring the Treatment of Behavioral Health and Substance Abuse services. YourChoice opts out of following Mental Health Parity Act per Federal regulations as a self-funded non-federal governmental entity. This means that the benefit design for Behavioral Health will not be in parity with the benefit design for the medical plan. Therefore, the visit limits and the member deductible, copay and coinsurance as reflected in the Behavioral Health schedule apply to applicable services. By opting out of the Mental Health Parity Act, members of the plan are not subject to deductibles and coinsurance for outpatient behavioral health services that they would be subject to if the Plan did not opt out of Mental Health Parity.

LAMP is the Employee Assistance Program and Behavioral Health Utilization Management division of the YourChoice Health Plan.

8.00.01 PLAN DESIGN

There is one Behavioral Health and Substance Abuse Plan for all members enrolled in the *Your Choice* Ultimate, Best, Better or Basic Plans.

Behavioral Health Services that are provided by the Network providers will be paid at the Highest Level of Reimbursement.

Behavior Health Services provided by a Non-Network Provider are paid at a Lower Level of Reimbursement and the member will be subject to balance billing.

The Benefits, Deductibles, Co-pays, Coinsurance, Exclusions and Limitation are separate from the Comprehensive Medical Benefits outlined in other Sections of this Plan.

8.00.02 SCHEDULE OF BEHAVIORAL HEALTH BENEFITS

EAP Services, Outpatient Counseling, Psychiatric and Psychological Testing

LEVEL OF CARE	ONSITE	IN-NETWORK	OUT OF NETWORK
LAMP/EAP Benefit **	5 Free Visits per calendar year-shared with Onsite and/or In-Network.		Not Applicable
Counseling *	$15 copay after the 5 free visit benefit is exhausted.	$25 copay after the 5 free visit benefit is exhausted.	$200 Deductible 40% Coinsurance after Deductible
Tele-Behavioral Health	Available for 1st 5 visits only	$25 copay after the 5 first free visit benefit is exhausted.	Not available
Psychological Testing* Requires Precertification	Not Applicable	$25 copay after the 5 free visit benefit is exhausted	Not Applicable
Psychiatric Services*	1st visit with no co-pay. $15 co-pay starting with the 2nd visit	$25 copay per visit	$200 Deductible 40% Coinsurance after Deductible
Group Therapy	One time $25 copay	$25 copay per session	$35 copay per session

*Counseling, Tele-Behavioral Health, Psychological Testing and Psychiatric Services all share the same benefit maximum of 42 visits per year. The 5 visits per calendar year at no cost are made up of counseling tele-behavioral health and psychological testing visits either Onsite or In Network.
** Tele-behavioral Services are available and eligible under the LAMP/EAP Benefit.

Inpatient and Intensive Outpatient Benefits

Precertification required for In and Out of Network Providers

LEVEL OF CARE	BENEFIT DESCRIPTION	IN NETWORK PROVIDER	OUT OF NETWORK PROVIDER
Outpatient Detox/Intensive Outpatient Program	Up to 3 hours of therapies per day to support substance relapse	**Coinsurance:** 20% of the Allowable. **Days Per Year:** 30 Days	**Deductible:** $300 per day up to 5 days **Coinsurance:** 40% after Deductible is met **Days per Year:** 30 Days
Partial Hospitalization-Mental Health and Substance Abuse Treatment	Up to 6 hours of therapies per day	Covered at 100%	**Deductible:** $300 per day up to 5 days. **Coinsurance**: 50% after deductible is met. **Days per Year**: 60 days.
Inpatient-SA or MH	Medically Necessary for the protection of self or others	Covered at 100%	**Deductible:** $300 per day up to 5 days **Coinsurance:** 40% after Deductible is met **Maximum Out of Pocket Expense:** $3,600 per Admission **Days per Year:** 30 Days

8.00.03 THIRD PARTY PROGRAM MANAGER

The Administrator for the behavioral health benefit is an Independent Administrator, contracted by the Plan Sponsor.

8.00.04 UTILIZATION MANAGEMENT AND CLAIMS REVIEW

Utilization management and claim review are provided by the Administrator for behavioral health, substance abuse.

8.00.05 FILING CLAIMS

Claims for EAP usage and for, the treatment of behavioral disorders and substance abuse program are filed with the carrier

8.00.06 MAXIMUM LIFETIME BENEFIT

Effective 1/1/2011, there is no lifetime maximum associated with the medical plan including behavioral health benefits.

8.01 PRE-APPROVAL FOR SERVICES

Most Covered Behavioral Health Services must be pre-approved by the behavioral health plan administrator's utilization management to receive plan benefits at the highest level of reimbursement

8.02 COVERED SERVICES

The Plan pays for In-Patient treatment, Partial Hospitalization, and Outpatient treatment and Psychological Testing upon applicable prior authorization and medical necessity. See Section 8.00.02.

8.03 BEHAVIORAL HEALTH EXCLUSIONS

The following are excluded from medical benefits and the treatment of mental health/substance abuse services, unless otherwise indicated.

1. Care and treatment of obesity, weight loss or dieting control unless preapproved by Utilization Management.
2. Vitamins, minerals, or food supplements whether prescribed by an eligible provider.
3. Biofeedback unless performed in conjunction with another covered service;
4. Mental Health services for remedial education, including evaluation, testing or treatment of learning disabilities;
5. Mental health services required by court order and/or condition of parole or probation;
6. Environmental ecological treatment;
7. Mega-vitamin or orthomolecular therapy;
8. Hypnotherapy unless performed as part of another covered service: and;
9. Weekend Admissions except for medical emergencies.
10. Experimental/Investigative drugs, chemicals, services or procedures. A drug, device, medical treatment or procedure is experimental or investigative if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing have not been given at the time the drug or device is furnished;
11. Charges which the member would not be legally required to pay if the member did not have the group health coverage, or if the Plan would not pay as written in medical and prescriptions plan exclusions unless specifically listed as a covered expense in the treatment of behavioral health section of the plan document.

8.04 AUTISM BENEFITS

The following outlines the coverage available to eligible members who meet criteria. This benefit coverage is separate from the medical plan and behavioral health coverage. All services are required to obtain prior authorization and all cases are enrolled in case management.

Requested Services: Services related to Autism, Asperger's Syndrome, and Pervasive Developmental Disorder NOS

Eligibility: Children under 18 years of age or in High School who have been diagnosed as having one of the identified developmental disabilities at 8 years of age or younger.

Summary of Coverage: Applied Behavioral Analysis (ABA), speech therapy, occupational therapy, physical therapy to address the diagnosis of one of the diagnoses listed above.

Maximum Benefit: $36,000 per year for Applied Behavioral Analysis and other therapies related specifically to the diagnosis listed above.

Cost Sharing:

Initial Diagnosis by a Developmental Physician: $25 copay

Speech Therapy: $10 copay per visit

Physical Therapy: $10 copay per visit

Occupational Therapy: $10 copay per visit

Exclusions related to Autism Services:

Team Meetings

Supervisions

Family Meetings

Consultations

Prescription Benefits

Prescription Plan Only Maximum Out-of-Pocket Expense *:
$1,400 per Individual

The Plan contracts directly with select Pharmacies in order to provide a lower out of pocket cost to the member and better Customer Service and reduced costs to the County. These are called Preferred Pharmacies.

Preferred Pharmacies include: Winn Dixie Pharmacies, Pelots Pharmacy, Apothicare Pharmacy
Retail Pharmacy: 90 Day Supply maximum at preferred pharmacy. 30 Day Supply maximum at non-preferred.

Maximum co-pay is $100.00 or Manufacturer's coupon per script for Retail and a maximum of $150.00 or Manufacturer's coupon for Specialty Medications and $300.00 or Manufacturer's coupon per script for Mail Order.

	PREFERRED PHARMACY	NON-PREFERRED PHARMACY
RETAIL		
Generic or Select OTC with a Prescription	$5 for 1-30 day supply	$15.00 or 20% whichever is greater
Preferred Brand	$15.00 or 25% whichever is greater	$20.00 or 30% whichever is greater
Non-Preferred	$40.00 or 45% whichever is greater	$50.00 or 55% whichever is greater
MAIL ORDER		
Generic	$18.00 or 15% whichever is greater	Not available
Preferred Brand	$38.00 or 25% whichever is greater	Not available
Non-Preferred	$100.00 or 50% whichever is greater	Not available
Specialty Pharmacy		
Generic or Brand per Script	25% coinsurance Maximum of $150.00 or manufacturer's coupon	$25% coinsurance Maximum of $150.00 or manufacturer's coupon

* Adjusted annually by the County Administrator. Maximum out-of-pocket expense does not include drug prescriptions when a member elects a Brand drug when a Generic drug is available or when a member elects a multi-source brand not on the Plans Preferred Drug list. Additional, copays covered by a manufacturer's coupon will not apply to the maximum out of pocket expense.

*** Refer to Manatee YourChoice Pharmacy Benefits for an approved list.

9.00 PRESCRIPTION PROGRAM

The Manatee Choice Prescription Plan is a carved-out pharmacy benefit. Benefits are not included in the medical plan section of the plan document.

The Benefits, Deductibles, Coinsurance and Co-payments, are separate from the comprehensive medical benefits outlined in other sections of the plan document.

9.00.01 APPLICABLE TO ALL COVERED PERSONS

All eligible members have access to the prescription benefit.

9.00.02 PRESCRIPTION PROGRAM MANAGEMENT

The Prescription Benefit Manager (PBM) is contracted by the Plan Sponsor. The contracted Clinical Pharmacist is responsible for the utilization management of the pharmacy benefit in conjunction with the contracted PBM.

The Prescription Benefit Manager is authorized to change co-payments applicable to the Prescription Drug Program with 30 days prior notice to the Plan participants and upon approval by the County Administrator.

The Plan Manager is authorized to change the Rules and Guidelines of the Prescription Drug Program upon approval of the County Administrator and reasonable notice to the Plan participants if practicable.

9.00.03 PREFERRED DRUG LIST

The Formulary is the Premium PDL offered by the contracted PBM. It includes a FDA approved brand name and generic prescription medications that are most effective in both clinical and financial outcomes. . The formulary is developed by the PBM and is adjusted periodically on the recommendation of the PBM. Not all medications that may be prescribed by a medical provider will be covered.

9.00.04 PRIOR AUTHORIZATION

Prior Authorization may be required for some prescriptions. Prior Authorization is reviewed by the Plan's Clinical Pharmacist and approved according to clinical guidelines and evidence-based criteria using clinical information provided by the prescribing physician. The Plan uses nationally accredited criteria to determine medical necessity and will utilize the most comprehensive criteria available to determine authorization.

9.00.05 STEP THERAPY

Step Therapy Guidelines are based upon the recommendation of the PBM. Step Therapy Guidelines are established for specific classes of prescriptions and is the trial of lower-cost medication(s) before a higher-cost medication can be covered. Details are listed in the plan's formulary.

9.00.06 QUANTITY LIMITS

Based upon the recommendation of the PBM, limits on the quantity of specific medications for specific disease states will be established.

9.01 ELIGIBLE PRESCRIPTION DRUGS

The Plan pays for eligible drugs if prescribed by a Physician authorized to write prescriptions according to the laws of the state where the prescription is purchased.

9.02 LIMITED COVERAGE PRESCRIPTION DRUGS

The following are only a partial list of drugs available with Prior Authorization by the PBM

- Specialty Medications (Oral and Injectable)

- Medications exceeding $1000
- Medications where reasonable alternatives exist that are medically appropriate
- Medications that could be inappropriately prescribed.
- Drugs for weight reduction or control

9.03 PLAN EXCLUSIONS

The Following Drugs are not covered:

- Drugs for infertility, including drugs for co-occurring conditions for the purpose of fertility if not otherwise indicated.
- Vitamin A derivatives such as Retin A when used for excluded conditions
- Hair restoration products such as Rogaine (topical minoxidil) or similar medications
- Rx strength vitamins except pre-natal vitamins
- Drugs not approved by the FDA
- Drugs for the treatment of erectile dysfunction
- Drugs excluded by the Medical Plan
- Experimental or Investigational Drugs

9.04 RETAIL PHARMACY EARLY REFILL EXCEPTION

At the Member's request, the Plan may authorize the early dispensing of a prescription for Members going on vacation or out of the area on business. The early refill authorization is to be for no more than one (1) refill per trip or two (2) refills in a calendar year.

The County Administrator or designee may authorize early refills for a Special Community Based Emergency or for other emergency events at the discretion of the County Administrator or designee.

SECTION 10 -DENTAL PLAN

10.00 PLAN SPONSOR

The Plan Sponsor is Manatee County Government's Board of County Commissioners. Aetna administers the dental plan and provides the Dental PPO/PDN Network for members.

10.00.01 PPO DENTAL PLAN

A Member selects the dentist of their choice to perform all services. Dentists listed in the Provider Directory agree to the Network Provider reimbursement rates and agree to not bill members for any difference between their fee schedule and their contracted rates.

10.00.02 CONTRIBUTION TOWARDS COVERAGE

An employee of Manatee County Government who desires individual and/or family coverage must contribute through Payroll Deduction. The Plan is self-insured and the County funds a portion of the benefits provided herein, with employees funding the remainder. The Plan is self-insured, and the participant pays 100% of the cost of the premium.

10.00.03 RATES

The Schedule of Benefits for the Dental Plan contains the Deductibles, Co-Payments, and Benefits for the Dental Plan for In and Out of Network usage

10.00.04 ELIGIBILITY

All Eligible Employees and their Dependents are eligible to enroll in the Dental Plan

10.00.05 WAITING PERIOD

Initial Eligibility:

A new Employee who is otherwise eligible will become eligible to join the Plan on the first day of the month following 60 days continuous full time employment.

Open Enrollment:

Employees and/or Dependents who are not enrolled during the Initial Eligibility Period or a Special Enrollment Period must wait until the next Open Enrollment Period to enroll for coverage to be effective the next designated Plan Year.

10.00.06 COORDINATION OF BENEFITS

The Plan has the right to coordinate benefits with any other Plan covering the individual and/or members of the Plan. No members of the Plan shall receive more than 100% of the charges covered by the Plan's coverage according to the fee schedule or any other Plan.

10.00.07 DENTIST

An individual duly licensed to practice Dentistry in the state where the dentist's service is performed and operating under the scope of his/her license.

10.00.08 PRE-TREATMENT REVIEW

If the charges for a course of treatment are projected to exceed $350 the Provider should submit a statement describing the Treatment Plan. The course of treatment would include all dental services or series of dental services to be received by the Covered Person for a condition, except the diagnosing exam. The statement should: (1) be on an approved form; (2) itemize the dental procedure recommended; (3) show the charge for each dental procedure; and (4) be accompanied by supporting x-rays, if requested. .

A determination will be made as to whether a less expensive course of treatment would be appropriate using the profession's accepted standards of dental practice. If no statement is submitted, benefits will be paid as if a Pre-treatment review had been submitted.

Pre-treatment review is not necessary for emergency care that would be required on an immediate basis because any delay would cause physical discomfort or aggravate the condition for which these services are required.

10.00.09 PRE-EXISTING CONDITION – SPECIAL LIMITATIONS

See section 10.02.14 (E) (D1), 10.03.05, 10.03.20

10.01 BENEFITS PAYABLE

Benefits are payable for covered charges as follows:

1. For procedures in the SCHEDULE OF BENEFITS the amount payable will equal the In Network Provider contracted rate (or the charge, if less) minus the Deductible if applicable. Network Dental Providers agree to not bill members for the difference between their billed charge and the amount payable. Non-Network Providers are reimbursed the Network Provider rate and may bill the patient for the remainder.

2. The total amount payable will not exceed the Calendar Year Maximum shown in Section 10, SCHEDULE OF BENEFITS.

10.01.01 DEDUCTIBLES

The dental plan has no annual deductible. Per Person $0

10.01.02 SECOND OPINION

The Plan will pay in full for an Office Consultation and X-rays if a member of the Plan desires a Second Opinion on Dental Services in excess of $500.00.

10.01.03 MAXIMUM ANNUAL BENEFIT

Calendar Year Maximum Per Person $2000.00

10.01.04 TERMINATION OF EMPLOYMENT

Your Personal Coverage will terminate on earliest to occur of the following:

1. The date on which the Plan Sponsor cancels the Plan.

2. The member fails to pay the required Premium equivalent.

3. The last day of the month following termination of employment.

Your Dependent Coverage will terminate on earliest to occur of the following:

1. Date on which your personal coverage terminates.

2. Date on which you cancel your dependent coverage.

3. The last day of the period for which contribution has been made, if you fail to make any required contribution.

4. The last day on which you are an eligible employee.

10.01.05 TERMINATION OF COVERAGE

No benefits will be available for eligible charges incurred after a covered person's benefits end except for COVERED

DENTAL EXPENSES incurred for treatment that is:

1. Started while a Covered Person is a member; and

2. Finished within 30 days after the Covered Person's coverage ends.

This Extension of Coverage is limited only to crowns, fixed bridges, inlays, onlays, full dentures, partial dentures and root canal therapy.

A Pre-determination for any dental treatment plan does not constitute treatment started.

10.01.06 CHANGE IN DEPENDENT STATUS

For individuals who become dependents midyear, the Special Enrollment Period available to subsequent dependents, outlined in Plan Sections 1.00.01 and 1.00.03 will apply. To the extent the Employee has not satisfied any required Waiting Period, coverage will not be effective before the end of that waiting period. For individuals who lose dependent status, their coverage will end, subject to any rights they may have under COBRA, pursuant to the provisions in Plan Section 1.06.01.

10.01.07 RETIREE

A Retiree enrolled in the Dental Plan on the Effective Date of his/her retirement is allowed to continue coverage. Enrollment is not available to Retirees not enrolled in the Dental Plan after the Retiree's date of retirement. Once a Retiree terminates coverage, the Retiree is not permitted to re-enroll in the Plan.

10.02 COVERED DENTAL CHARGES

Covered Dental Charges are charges which are: (1) prescribed, performed, or ordered by a dentist; and (2) Reasonable and Customary charges; and (3) incurred while You and your Dependents are covered under this Plan; and (4) not excluded by other provisions of the Plan that apply to the procedures described in the chart below:

Deductible/Coinsurance and Maximum Benefit	
Deductible	$0 per person
Preventative Services	100% of contracted rate covered
Basic Services	90% of contracted rate covered
Major Services	60% of contracted rate covered
Annual Benefit Maximum	$2,000
Orthodontic Services (Adult and Child)	50%
Orthodontic Lifetime Maximum	$2,000
Preventative Services	**Plan Responsibility**
Oral Examination (2 per calendar year)	100%
Cleanings (2 per calendar year)	100%
Fluoride (1 application/year under age 16)	100%
Sealants (1 treatment every 3 rolling years on permanent molars only for children to age 13)	100%
Bitewing X-rays (1 set per calendar year)	100%
Full Mouth Series (1 set every 24 months)	100%
Space Maintainers (covered to age 13 for premature loss of primary teeth only. Includes adjustment w/in 6 months of installation)	100%

Basic Services	Plan Responsibility
Root canal therapy (anterior teeth/Bicuspid teeth)	90%
Root canal therapy, molar teeth	90%
Scaling and root planing (4 separate quads every 2 rolling years)	90%
Gingivectomy (once per quad/site every 3 rolling years)	90%
Amalgam (silver) fillings	90%
Composite fillings (anterior & posterior teeth only)	90%
Stainless steel crowns	90%
Incision and drainage of abscess	90%
Uncomplicated extractions	90%
Surgical removal of erupted tooth	90%
Surgical removal of impacted tooth (soft tissue)	90%
Osseous surgery (a*)	90%
Surgical removal of impacted tooth (partial bony/full bony)*	90%
General anesthesia/intravenous sedation*	90%
Major Services	**Plan Responsibility**
Crown Lengthening	60%
Inlays	60%
Onlays	60%
Crowns	60%
Full and Partial dentures	60%
Implants	60%
Pontics	60%
Denture repairs	60%
Crown Build-ups	60%
*Covered under dental if not covered in whole or part under medical	

10.02.01 REPLACEMENT DENTAL PROCEDURES

a. repair or re-cementing of crowns, inlays, or bridges.

b. repair or relining of dentures. (Not more than one relining in a Calendar Year).

c. installing partial or full dentures for the first time due to the extraction of one or more natural teeth extracted while covered. (This includes adjustments made within 6 months following the installation).

d. replacement of an existing partial or full denture, crown, or fixed bridge by a new denture, crown or bridge, or the addition of teeth to an existing denture or bridge to replace extracted natural teeth only if:

1) the existing denture, crown or bridge cannot be made serviceable and was installed at least 5years before it is replaced; or

2) the existing denture is an immediate denture and must be replaced by a permanent denture, and the replacement is made within 12 months from the date the immediate denture was installed; or

3) 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.

Replacement benefits will not exceed the amount that would be payable for the same type of denture, crown, or fixed bridge being replaced.

e. inlays, onlays, gold fillings, crowns, and installation of fixed bridges for the first time. Bridges are covered only if they are for replacement of one or more natural teeth extracted while covered.

REPLACEMENT DENTAL PROCEDURES

The incurred date for Covered Dental Charges is as follows:

Dentures-on the date the impression is taken.

Fixed Bridges/Crowns-on the date the tooth is first prepared.

Root Canal Therapy-the date the tooth is opened by the dentist.

All other Treatment-on the date the work is done.

Benefits will be paid only after treatment is completed.

When there is more than one way to properly treat a particular dental problem, benefits will be payable for the least expensive course of treatment.

10.02.02 EXTENDED BENEFITS UPON PLAN TERMINATION

Dental Benefits will be extended if this Plan terminates while a Covered Person is receiving dental treatment in connection with a specific accident or sickness incurred while this coverage was in effect. Dental Benefits will not be extended for Preventive/Diagnostic Dental Procedures. Dental benefits will not be extended if the Covered Person is covered under another plan which provides dental benefits equal to or greater than the benefits provided under this Plan. Extended Benefits for dental treatment will terminate upon the earliest of:

1. the date 30 days after the date this Coverage terminates; or

2. the date the Covered Person becomes covered under another plan which provides dental benefits equal to or greater than the benefits provided under this Coverage.

10.03 EXCLUSIONS

No benefits will be paid for charges in connection with:

1. services or supplies for which a Covered Person is not required to pay or charges made only because coverage exists (subject to the right, if any, of the US government to recover Reasonable and Customary Charges for care provided in a military or veteran's hospital); or

2. treatment resulting from an on-the-job Sickness or Injury or condition covered by Worker's Compensation or any Occupational Disease or similar law whether benefits are insured or self-insured; or charges made for or in connection with any Sickness or Injury arising out of or in the course of any employment for wage or profit. This includes self-employment or employment by others, whether or not Worker's Compensation or any Occupational Disease or similar law covers the charges incurred and whether the charges are covered on an insured or uninsured basis; or

3. the replacement of lost or stolen prosthetic device; or

4. 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; or

5. subject to the dental Pre-existing Conditions limitation, the first installation if all teeth that will be replaced were extracted prior to the date the person became covered. (Bridges include crowns and inlays that form the abutments.);or

6. subject to the Dental Pre-existing Conditions limitation, prosthetic devices and their fitting, for which treatment began prior to the date the person became covered. (This includes bridges and crowns); or

7. any act due to war, if declared or not; or

8. extra sets of dentures or other appliances; or

9. counseling on diet or nutrition; or

10. experimental procedures; or

11. completion of any forms; or

12. appliances, restoration, and procedures to alter vertical dimension or restore occlusion; or

13. veneers or similar properties of crowns and pontics placed on or replacing teeth, other than the 10 upper and lower front teeth; or

14. failure to keep an appointment; or

15. care, treatment, services or supplies:

    a. furnished mainly for cosmetic purposes; or

    b. to the extent benefits are payable under the other provisions of this Plan; or

    c. not paid due to the Deductible or Co-payment provisions of this Plan; or

    d. received in US government facilities (subject to the right, if any, of the US government to recover Reasonable and Customary Charges for care provided in a military or veteran's hospital); or

    e. provided or paid for by any governmental plan or law not restricted to the government's civilian employees and their dependents.

16. No benefits payment shall be made for charges incurred after the date this Plan is terminated.

17. Treatment of Temporomandibular Joint that is covered under a Medical Plan.

SECTION 11 - GENERAL PROVISIONS

11.00 CONTINUATION OF COVERAGE - COBRA

If coverage under this Plan would have stopped due to a Qualifying Event, a Qualified Beneficiary may elect to continue coverage subject to the provisions below.

The Qualified Beneficiary may continue only the coverage in force immediately before the Qualifying Event.

The coverage being continued will be the same as the coverage provided to similarly situated individuals to whom a Qualifying Event has not occurred.

Coverage will continue until the earliest of the following dates:

- 18 months from the date the Qualified Beneficiary's health coverage would have stopped due to a Qualifying Event based on employment stopping or work hours being reduced.

- 36 months from the date the health coverage would have stopped for the spouse or child of an Employee due to divorce or death of the employee, or a child who no longer qualifies for the plan due to age

- 36 months from the date of the Employee's Medicare Entitlement if this event occurs prior to termination of employment or reduction of work hours or 18 months from the date of the qualifying event, if later. This extended period applies to Spouse and Children only.

- 29 months for all family members entitled to continuation coverage, if one of the Qualified Beneficiaries is determined to be disabled under the Social Security Act at any time during the first 60 days of continued coverage due to the employee's employment stopping or reduction of work hours. The Qualified Beneficiary must provide the Employer with the Social Security Administration's determination of disability within 60 days of the time the determination is made and within the initial 18-month continuation period. The Qualified Beneficiary must agree to pay any increase in the required payment necessary to continue the coverage for the additional 11 months.

- The date this Plan stops being in force.

- The date the Qualified Beneficiary fails to make the required payment for the coverage.

- The date the Qualified Beneficiary, after electing this continuation, becomes covered under Medicare or any other group health plan. (This does not apply if the other group health plan excludes or limits coverage for a Qualified Beneficiary's pre-existing condition.)

If within the original 18 month continuation period, another Qualifying Event occurs, coverage can be continued for an additional period, for a total of 36 months from the date of the first Qualifying Event.

Coverage will stop for the same reasons as coverage would have stopped for the first Qualifying Event.

Election Period

A Qualified Beneficiary has at least 60 days to elect to continue coverage. The election period ends on the later of:

- 60 days after the date coverage would have stopped due to the Qualifying Event.

- 60 days after the date the person receives notice of the right to continue coverage.

Unless otherwise specified, an Employee or spouse's election to continue coverage will be considered an election on behalf of all other Qualified Beneficiaries who would also lose coverage because of the same Qualifying Event.

Required Payments

A Qualified Beneficiary has 45 days from the date of election to make the first required payment for the coverage. The first payment will include any required payment for the continued coverage as well as any premium costs incurred and owed prior

to the COBRA election before the date of the election.

Notification Requirements

- A Qualified Beneficiary must notify the Employer within 60 days when any of the following Qualifying Events happen:
- The Qualified Beneficiary's marriage is dissolved.
- A child stops being an eligible Dependent.

The Employer will send the appropriate Election Form to the Qualified Beneficiary within 14 days after receiving this notice.

Special Terms that Apply to this Continuation Provision

Qualifying Event

A Qualifying Event is any of the following which results in loss of coverage for a Qualified Beneficiary:

- The Employee's employment ends (except in the case of gross misconduct).
- The Employee's work hours are reduced resulting in loss of coverage.
- The Employee becomes entitled to benefits under Medicare.
- The Employee's death.
- The Employee's marriage is dissolved.
- The Employee's Dependent child stops being an eligible Dependent.

A bankruptcy is a Qualifying Event for certain Retired Employees and their Dependents under certain conditions. If there is a bankruptcy, Retired Employees should contact the Employer or the Company for more information.

Qualified Beneficiary

Any of the following persons who are covered under the plan on the day before a Qualifying Event:

- The Employee.
- An Employee's spouse.
- An Employee's former spouse (or legally separated spouse).
- A Dependent child, including a child born to or placed for adoption with the Employee during a period of continued coverage.

11.01 SUBROGATION PROVISION

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, the Plan Sponsor shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and benefits the Plan Sponsor provided to Covered Persons, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Plan, the Plan Sponsor shall also have an independent right to be reimbursed by Covered Persons for the reasonable value of any services and benefits the Plan Sponsor provides to Covered Persons, from any or all of the following listed below.

- Third parties, including any person alleged to have caused a Covered Person to suffer injuries or damages.

- A Covered Person's employer.

- Any person or entity who is or may be obligated to provide benefits or payments to a Covered Person, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.

- Any person or entity that is liable for payment to a Covered Person on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties",

Covered Person agrees as follows:

To cooperate with the Plan Sponsor in protecting its legal and equitable rights to subrogation and reimbursement, including, but not limited to:

- providing any relevant information requested by the Plan Sponsor,

- signing and/or delivering such documents as the Plan Sponsor or its agents reasonably request to secure the subrogation and reimbursement claim,

- responding to requests for information about any accident or injuries, making court appearances, and

- obtaining the Plan Sponsor's consent or its agents' consent before releasing any party from liability or payment of medical expenses.

That failure to cooperate in this manner shall be deemed a breach of contract and may result in the termination of health benefits or the instigation of legal action against a Covered Person.

That the Plan Sponsor has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

That no court costs or attorneys' fees may be deducted from the Plan Sponsor's recovery without the Plan Sponsor's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan Sponsor is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a Covered Person to pursue his or her damage/personal injury claim.

That regardless of whether a Covered Person has been fully compensated or made whole, the Plan Sponsor may collect from Covered persons the proceeds of any full or partial recovery that a Covered Person or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.

That benefits paid by the Plan Sponsor may also be considered to be benefits advanced.

That Covered Persons agree that if they receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, the Covered Persons will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of his or her duties hereunder.

That Covered Persons or an authorized agent, such as the Covered Person's attorney, must hold any funds due and owing the Plan Sponsor, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against the Covered Person.

That the Plan Sponsor may set off from any future benefits it otherwise provided, the value of benefits paid or advanced under this section to the extent not recovered by the Plan Sponsor.

That a Covered Persons will not accept any settlement that does not fully compensate or reimburse the Plan Sponsor without its written approval, nor will a Covered Person do anything to prejudice the Plan Sponsor's rights under this provision.

That Covered Persons will assign to the Plan Sponsor all rights of recovery against Third Parties, to the extent of the reasonable

value of services and benefits the Plan Sponsor provided, plus reasonable costs of collection.

That the Plan Sponsor's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom the Covered Person is seeking recovery, to be paid before any other of the Covered Person's claims are paid.

That the Plan Sponsor may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in a Covered Person's name, which does not obligate the Plan Sponsor in any way to pay a Covered Person part of any recovery the Plan Sponsor might obtain.

That the Plan Sponsor shall not be obligated in any way to pursue this right independently or on a Covered Person's behalf.

11.02 SPECIAL MEDICARE PROVISION

Any benefits covered under both this Plan and Medicare will be paid pursuant to Medicare Secondary Payer legislation, regulations and Health Care Financing Administration guidelines, subject to federal court decisions. Whenever there is a conflict between state law, Plan provisions and federal law, federal law is preeminent.

- The County's Plan wraps around Medicare Part A, pays deductibles and coinsurance up to the Medicare Part A maximum benefit.
- The plan wraps around Part B and pays the deductible and coinsurance up to the Plans maximum allowed benefit.
- The plan pays for any services rejected by Medicare covered by the plan up to the maximum benefit.

11.03 SPECIAL PROVISION APPLICABLE TO EMPLOYED DEPENDENTS

For any dependent eligible for coverage under another plan, insured or self-insured, or where the Dependent's Employer pays 100% of the premium or premium equivalent, by virtue of his or her employment, but who is not enrolled under that plan, the benefits of this Plan will be payable only to the extent that benefits would not have been paid were the dependent actually enrolled in the plan offered by his or her place of employment.

11.04 COORDINATION OF BENEFITS

(This provision does not apply to Prescription Drug Benefits.)

Coordination of benefits applies when a covered Employee or a covered Dependent has health coverage under this Plan and one or more Other Plans.

One of the plans involved will pay the benefits first: that plan is Primary. Other Plans will pay benefits next: those plans are Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary.

Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than the Allowable Expenses charged for that Calendar Year.

Definitions

"Other Plans" are any of the following types of plans which provide health benefits or services for medical care or treatment:

- Group policies or plans, whether insured or self-insured. This does not include school accident-type coverage.
- Group coverage through HMOs and other prepayment, group practice and individual practice plans.
- Group-type plans obtained and maintained only because of membership in or connection with an organization or group.
- Government or tax supported programs. This does not include Medicare or Medicaid
- No-Fault motor vehicle laws.

"Primary Plan": A plan that is Primary will pay benefits first. Benefits under that plan will not be reduced due to benefits payable under Other Plans.

"Secondary Plan": Benefits under a plan that is Secondary may be reduced due to benefits payable under Other Plans that are Primary.

"Allowable Expenses" means the necessary, reasonable and customary expense for health care when the expense is covered in whole or in part under at least one of the plans.

The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an Allowable Expense unless the patient's stay in a private Hospital room is necessary either in terms of generally accepted medical practice, or as defined in the plan.

When a plan provides benefits in the form of services, instead of a cash payment, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

How Coordination Works

When this Plan is Primary, it pays its benefits as if the Secondary Plan or Plans did not exist.

When this Plan is a Secondary Plan, its benefits are reduced so that the total benefits paid or provided by all plans during a Calendar Year are not more than total Allowable Expenses. The amount by which this Plan's benefits have been reduced shall be used by this Plan to pay Allowable Expenses not otherwise paid, which were incurred during the Calendar Year by the person for whom the claim is made. As each claim is submitted, this Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Calendar Year.

The benefits of this Plan will only be reduced when the sum of the benefits that would be payable for the Allowable Expenses under the Other Plans, in the absence of provisions with a purpose like that of this **Coordination of Benefits** provision, whether or not claim is made, exceeds those Allowable Expenses in a Calendar Year.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Which Plan Pays First

When two or more plans provide benefits for the same Covered Person, the benefit payment will follow the following rules in this order:

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The Plan which covers the person other than as a dependent will be the primary payer.
- This plan will be the primary payer if this plan covers a person as a dependent and the only other plan that does not cover the person as a dependent is Medicare and Medicare requires this plan to be the primary payer.
- Medicare is secondary to the plan covering the person as a dependent.
- Medicare is primary to the plan covering the person as other than a dependent (example, a retired employee).
- When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

If the other plan does not have a birthday rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

First, the plan of the parent with custody for the child.

Second, the plan of the spouse of the parent with the custody of the child.

Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to payor provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This rule does not apply with respect to any claim for which any benefits are actually paid or provided before the entity has that actual knowledge.

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.

The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same rule applies if a person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a husband or wife is covered under this Plan as an Employee and as a Dependent, the Dependent benefits will be coordinated as if they were provided under another group health plan. This means the person's Employee benefits will pay first.

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber for the longer period are determined before those of the plan which covered that person for the shorter period.

Right to Exchange Information

In order to coordinate benefit payments, the Company needs certain information. It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this.

A Covered Person must give the Company the information it asks for about other plans. If the Covered Person cannot furnish all the information the Company needs, the Company has the right to get this information from any source. If any other organization or person needs information to apply its coordination provision, the Company has the right to give that organization or person such information. Information can be given or obtained without the consent of any person to do this.

Facility of Payment

It is possible for benefits to be paid first under the wrong plan. The Company may pay the plan or organization or person for the amount of benefits that the Company determines it should have paid. That amount will be treated as if it was paid under this Plan. The Employer or Plan will not have to pay that amount again.

Right of Recovery

The Company may pay benefits that should be paid by another plan or organization or person. The Employer or Plan may recover the amount paid from the other plan or organization or person.

Benefits may be paid that are in excess of what should have been paid under this Plan. The Employer or Plan has the right to recover the excess payment.

11.05 PHYSICAL EXAMINATION AND AUTOPSY

The Plan Sponsor, at its expense, has the right to have a Physician of its choice examine any Covered Person as often as reasonably necessary while there is a claim pending. The Plan Sponsor also has the right to have an autopsy performed, unless it is not permitted by law.

11.06 LEGAL ACTIONS

No Covered Person may sue on a claim before exhausting the claim review procedures of the Plan or 60 days after the claim has been given to the Plan, whichever is later. The Covered Person may not sue after three years from the time proof of loss is required, unless the law in the area where the covered Employee lives allows for a longer period of time

11.07 POLICY TERMINATION

Termination of Coverage under this Plan by the Plan Sponsor will be without prejudice to any claim originating prior to the date of termination.

11.08 FILING A CLAIM

A Claim must be submitted to the third-party administrator in writing. It must give proof of the nature and extent of the loss. Claims may be submitted direct to the third party administrator by your physician or claim forms can be found on the Manatee Your Choice Website. All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss. If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

Under the Plan, you may file claims for Plan benefits and appeal adverse determinations. Any reference to "you" or "claimant" in this claim and appeals section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from the third-party administrator. The notice will explain the reason for the denial and the appeal procedures available under the Plan.

11.09 APPEAL BY COVERED PERSON

A claimant will have sixty (60) days after the date of the claim denial to ask for a review. A written request for a review must be filed with the Plan's Third Party Administrator. The carrier and the Plan have 60 days to respond to all appeals.

11.10 APPEAL PROCEDURES

The Plan Sponsor will have sixty (60) days from the date the claimant submits an appeal during which to reconsider the claim. If special circumstances require an extension of time, the Plan Sponsor may have an additional sixty (60) days to answer. If the claim is again denied, the Plan Sponsor will provide a written denial, which will state the reasons for the denial, and refer the claimant to the Plan provisions upon which its decision is based. The Plan Sponsor may, but is not required to, appoint a committee to consider appeals filed by claimants. The decisions of the Plan Sponsor (or the committee, if applicable) shall be given the greatest deference allowable by law and shall be binding and conclusive with respect to all Covered Persons under the Plan. Upon issuance of a final decision by the Plan Sponsor or the committee, a Covered Person must bring suit in a court of competent jurisdiction within three (3) years of the issuance of such denial or be forever foreclosed from bringing suit with regard to such claim.

11.11 RIGHT OF RECOVERY

If payment for claims made by the Plan Sponsor are more than the amount payable under this Plan, the Plan Sponsor may recover the overpayment. The Plan Sponsor may seek recovery from one or more of: (1) any Covered Person to or for whom benefits were paid; (2) any other insurers; (3) any Institution, Physician or other provider of medical care; or (4) any other organization.

The Plan Sponsor shall be entitled to deduct the amount of any such overpayment from any future claims payable to the Covered Person or the Covered Person's Dependents.

11.12 PLAN SPONSOR'S SOLE DISCRETION

The Plan Sponsor may, at its sole discretion, pay benefits for services and supplies not specifically covered by the Plan. This applies if the Plan Sponsor determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of the Covered Person.

11.13 WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

The Women's Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans and health insurance issuers that provide

coverage for medical and surgical benefits with respect to mastectomies must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema).

11.14 UNIFORMED SERVES EMPLOYEMENT AND RE-EMPLOYEMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for eligible Employees and Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage.

SECTION 12 - DEFINITIONS

1. **ALCOHOLISM OR DRUG DEPENDENCY TREATMENT CENTER** means a Facility that provides a program for the treatment of alcohol or other drug dependency by means of a written treatment plan that is approved and monitored by a Physician. This Facility must be: (1) affiliated with a Hospital under a contractual agreement with an established system for patient referral; (2) accredited by the Joint Commission on Accreditation of Hospitals; (3) licensed, certified, or approved as alcoholism or other drug dependency treatment program or center by any other state agency that has the legal authority to do so.

2. **ALTERNATIVE BIRTHING CENTER** is a specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located. A Birth Center which is part of a Hospital, as defined herein shall be considered an Ambulatory Surgical Center for the purposes of this Plan.

3. **AMBULATORY SURGICAL CENTER** is a specialized facility which is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures an which is licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.

4. **BOARD OF COUNTY COMMISSIONERS** is the governing body of Manatee County: The Board retains the power to authorize all substantive changes to this Plan Document, including adding or deleting coverage or programs and amending fee schedules, which authority is not otherwise specifically delegated in this agreement.

5. **BONE MARROW TRANSPLANT** means human blood precursor cells administered to a Covered Person to restore normal hematological and immunological functions following ablative therapy with curative intent.

6. **CERTIFIED NURSE-MIDWIFE** means a Nurse (R.N.) who: (1) has graduated from an accredited School or Nurse-Midwifery; and (2) is licensed by the State Board of Nursing and the American College of Nurse-Midwives.

7. **CLASS means** Active, Retiree or COBRA participant.

8. **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended

9. **COMMUNITY MENTAL HEALTH CENTER** means a private tax-exempt entity or a public entity created by the Private Act of the General Assembly that: (1) primarily provides services for the diagnosis and treatment of emotionally disturbed and mentally ill persons; (2) has a requirement that all mental health care be under a treatment plan approved and reviewed by a Physician; (3) has arranged that patients who need medical services can be referred to a Physician or Hospital; (4) has been licensed as a mental health clinic Institution by the Department of Mental Health or by the Licensing Board of the State in which t is located; (5) has facilities for Inpatient care; and (6) has a certificate of need from the Health Facilities Commission in this state, if required by law.

10. **COMPLICATIONS OF PREGNANCY** means: (1) conditions that require Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy and not constituting a mosologically distinct Complication of Pregnancy; and (2)non-elective cesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

11. **CONVALESCENT OR SKILLED NURSING FACILITY means an Institution constituted, licensed, and operated as set** forth in the laws that apply, which (1) mainly provides Inpatient care and treatment for Covered Persons who are convalescing from a Sickness or Injury; (2) provides care supervised by a Physician; (3) provides 24 hour per day nursing care by Nurses, that are supervised by a full-time Nurse (R.N.); (4) keeps a daily clinical record of each patient; (5) is not a place primarily for the aged, drug addicts, or alcoholics; and (6) is not a rest, educational, or custodial Institution or similar place.

12. **COSMETIC SURGERY** means surgery that is intended to: (1) improve the appearance of the patient; or (2) preserve or restore a pleasing appearance. It does not mean surgery that is intended to correct normal functions of

the body.

13. **COVERED HEALTH SERVICES** are those health services, supplies, or equipment provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or symptoms. In order to be considered Covered Health Services, services must be provided:

    - when the plan is in effect;
    - prior to the date that any of the individual termination conditions set forth in this Summary Plan Description; and
    - when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan

    A Covered Health Service must meet each of the following criteria:

    - It is supported by national medical standards of practice;
    - It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes and are based on trials that meet nationally recognized standards for conducting medical research.
    - It is the most cost-effective method and yields a similar outcome to other available alternatives.

14. **COVERED EMPLOYEES** are those officers and employees of Manatee County Government and those of the Tax Collector, the Property Appraiser, the Supervisor of Elections, the Clerk of the Circuit Court, Port Authority, Metropolitan Planning Organization (MPO) and the Sheriff of Manatee County, plus individual retirees and COBRA individuals (not dependents), as well as the officers and employees of such other governmental agencies that the Manatee County Board of County Commissioners may add to the Plan's coverage.

15. **COVERED PERSON** means Covered Employees and their Dependents covered under the Plan.

16. **CUSTODIAL CARE** is care that is given principally for personal hygiene or for assistance in the activities of daily living which can, according to generally accepted medical standards, be performed by persons who have no medical training.

17. **DEPENDENT COVERAGE** means the coverage for the Dependents of all of the Employees who are eligible to be covered.

18. **EMERGENCY CARE** is medical care and treatment provided for a medical condition manifesting itself by acute symptoms which are severe enough that the lack of immediate medical attention could reasonably be expected to result in the person’s health being placed in serious jeopardy.

19. **EMPLOYEE** means a person who is directly employed by the Employer for pay in the conduct of the Employer's regular business.

20. **EMPLOYEE COVERAGE** means the coverage for all of the Employees who are eligible to be covered.

21. **EMPLOYER** means the Plan Sponsor. It also includes any of the constitutional officers, agencies and other Employees approved by the Plan Sponsor.

22. **EVIDENCE BASED NATIONAL GUIDELINES** means the conscientious, explicit and judicious use of current best evidence in making decisions about the Medically Indicated care of the individual patient based upon a review of the available clinical information, clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, and positions of leading national health professional organizations. This does not mean that the service or supply will be covered benefit under the Plan.

23. **FULL-TIME EMPLOYEE** means an Employee who is on the Employer's regular payroll as a common-law Employee and either (i) averaged at least 30 hours of service for each week during the governing measurement

period (as that term is defined in the Affordable Care Act), or (ii) is a new Employee expected to average at least 30 hours of service per week. An employee who satisfied this definition but is not classified as a full-time employee for other purposes may be treated as a Full-Time Employee exclusively for the purposes of the medical Plan.

24. **GENETIC INFORMATION** means information about genes, gene-products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

25. **HEALTHBUCKS** means cafeteria plan flex credits earned by employees.

26. **HEALTH CARE PROVIDERS** mean Physicians, Licensed Providers, Hospitals or Institutions providing medical care or services to Covered Persons.

27. **HEALTH COVERAGE** means coverage under this Plan that provides benefits for Hospital, surgical and medical charges that are incurred by a Covered Person.

28. **HOME HEALTH CARE AGENCY** means a public or private agency or organization licensed in the state in which it is located, to provide Home Health Care Services.

29. **HOME HEALTH CARE SERVICES** consist of services that are Medically Indicated for the care and treatment of covered Sickness or Injury furnished to a Covered Person at his or her place of residence.

30. **HOSPICE** means a coordinated plan of home or Inpatient care which treats the terminally ill patient and family as a Family Unit. It provides care to meet the special needs of the Family Unit during the final stages of a terminal illness and during bereavement. Care is provided by a team of trained medical personnel, homemakers and counselors. The Hospice must meet the licensing requirements of the state or locality in which it operates.

31. **HOSPITAL** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets one of these tests:

    - It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations.

    - It is approved by Medicare as a Hospital.

    - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians and continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and is operated continuously with organized facilities for operative surgery on the premises.

    - It is a facility operating as a psychiatric Hospital or residential treatment facility for mental health and is established and operated in accordance with the licensing and other laws of the state in which it is located.

    - It is a facility operating primarily for the treatment of Substance Abuse which maintains permanent and full-time facilities for bed care and full-time confinement of a least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour-a-day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse and which is established and operated in accordance with the licensing and other laws of the state in which it is located.

32. **INJURY** means an Injury to the body that is sustained accidentally.

33. **INPATIENT** means a Covered Person who is confined in a Hospital or a Convalescent or Skilled Nursing Facility and is charged for Room and Board.

34. **INSTITUTION** means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to a Covered Person, such as a Hospital. Convalescent or Skilled Nursing Facility, Ambulatory Surgical Center, Psychiatric Hospital, Community Mental Health Center, Residential Treatment

Facility, Psychiatric Treatment Facility, Alcoholism or Drug Dependency Treatment Center, Alternative Birthing Center, Home Health Center, Hospice, or any other such facility that the Plan Sponsor approves.

35. **INTENSIVE CARE UNIT** means a separate part of a Hospital that is reserved for critically and seriously ill patients who require highly skilled nursing care and constant or close and frequent audio-visual nursing observation. The Intensive Care Unit must provide its patients with: (1) Room and Board; (2) nursing care by Nurses who work only in the unit; and (3) special equipment and supplies that are primarily for use within the unit.

36. **AETNA POS II (OPEN ACCESS)** is an Aetna administered Preferred Provider Network operating across the country. Access to the Aetna POS II (Open Access) Network is only available to persons enrolled in the Plan Sponsored Medical and Dental Plans. NETWORK HOSPITAL means an Institution which meets the definition of a Hospital in this Plan that has an enforce contract with Aetna Choice POS II (open access) Aetna, at the time the services are rendered, to provide hospital services to Covered Persons.

37. **NETWORK INSTITUTION** means an Institution, such as a laboratory or Outpatient Surgery Facility that has an in-force Aetna Choice POS II (open access) contract with Aetna, at the time services are rendered, to provide medical services to Covered Persons.

38. **NETWORK PHYSICIAN** means a physician who meets the definition of physician in this Plan who has an enforce Aetna Choice POS II (open access) contract with Aetna, at the time the services are rendered, to provide health care services to Covered Persons.

39. **NETWORK PROVIDER** means any Aetna Choice POS II (open access) Health Care Provider licensed to treat injuries or sicknesses or to provide services covered by this Plan that complies with the terms and conditions established by Aetna for designation as an Aetna POS II (Open Access) Provider. SERVICE AREA means any county that there is an Aetna POS II (Open Access) panel of providers established.

40. **MEDICALLY INDICATED CARE OR MEDICAL NECESSITY** are those health care services and supplies which are determined by the Plan to be medically appropriate, and are

    - necessary to meet the basic health needs of the Covered Person; and
    - rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply; and
    - consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Plan; and
    - consistent with the diagnosis of any condition, Injury, or Sickness of the Covered Person; and
    - required for reasons other than the convenience of the Covered Person or his or her provider; and
    - demonstrated through prevailing peer-reviewed medical literature to be either:
    - safe and effective for treating or diagnosing the condition, Injury, or Sickness, for which their use is proposed; or
    - safe with promising efficacy for treating a life-threatening condition, Injury, or Sickness in a clinically controlled research setting using a specific research protocol that meets standard equivalent to those defined by the National Institutes of Health.

    The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only procedure or treatment for a condition, Injury, or Sickness does not mean that it is Medically Indicated or of Medical Necessity.

41. **MEDICARE** means any coverage under Title XVIII of the Federal Social Security Act. If this Act is amended, this term will mean any coverage provided under the amended act.

42. **NON-SCHEDULED ADMISSION** means a hospital admission that is not a Scheduled Admission.

43. **NURSE** means: (1) Registered Nurse (R.N.); (2) Licensed Practical Nurse (L.P.N.); or (3) Licensed Vocational Nurse (L.V.N.), licensed by the State Board of Nursing.

44. **OUTPATIENT** means a Covered Person who receives care in a Hospital or other Institution, including: Ambulatory Surgical Center; Convalescent or skilled Nursing Facility; or Physician's office for a Sickness or Injury, but who is not confined and is not charged for Room and Board.

45. **PARTIAL HOSPITALIZATION SERVICES** means services for: (1) mental illness; (2) drug dependency; or (3) alcoholism, offered by programs accredited by (1) the Joint Commission on the Accreditation of Hospitals; or (b) in compliance with equivalent standards, licensed, certified, or approved by the State or any other agency that has the legal authority to do so.

46. **PART-TIME OR TEMPORARY EMPLOYEE** means an Employee who is classified in a position that is not eligible to participate in this Plan until and unless he or she satisfied the definition of "Full Time Employee".

47. **PHYSICIAN** is a legally qualified Doctor of Medicine (M.D.), Doctor of Chiropody (D.S.C.), Doctor of Chiropractic (D.C.), Doctor of Dental Surgery (D.D.S.), Doctor of Medical Dentistry (D.M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Optometrist (O.D.), Psychologist (Ph.D. or Psy. D.)

48. **PLAN ADMINISTRATOR** is designated by the County Administrator.

49. **PLAN DOCUMENT** is the written descriptions of all medical and dental benefit plans, including covered and non-covered services, deductibles and co-payments, and other provisions necessary to effectively administer and fund employee health benefits for Plan Members. .

50. **PLAN MANAGER** is the County employee designated by the Plan Administrator who will be primarily responsible for day-to-day management of the Plan and routine contracts with the TPA. The Plan Manager's duties, responsibilities and authority are specified in the Administrative Services Agreement.

51. **PLAN SPONSOR** is the Board of County Commissioners.

52. **PLAN YEAR** is defined as the Calendar Year

53. **PRE-EXISTING CONDITION** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within three months of the person's Enrollment Date under his Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician. The Pre-existing condition clause for the medical plan was eliminated by the Affordable Care Act effective 1/1/2014.

54. **PSYCHIATRIC HOSPITAL** means an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which: (1) is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons, either by or under the supervision of Physician; (2) maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided; (3) is licensed as a Psychiatric Hospital; (4) requires that every patient be under the care of a Physician; and (5) provides 24 hour nursing service. The Term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for (1) nursing care; (2) rest care; (3) convalescent care; (4) care of the aged; (5) Custodial Care; or (6) educational care.

55. **REASONABLE AND CUSTOMARY CHARGE(S)** as to charges for services rendered by or on behalf of a Network Provider is an amount not to exceed the amount determined by the Plan in accordance with the applicable fee schedule. As to all other charges, an amount which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. In determining this amount, the Plan will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

56. **RETIRED EMPLOYEE OR RETIREE** means a former Employee who is vested with the Florida Retirement System and is eligible to participate in a Governmental Agency Medical Plan according to Florida Statute or meets

the rules of the participating employer to be Eligible for Retiree Benefits.

57. **ROOM AND BOARD** means: (1) room and meals; and (2) all general nursing services which are required for the care of Inpatients in a Hospital or other Institution. Charges for Room and Board must: (1) be billed by the Hospital or other Institution on its own behalf; and (2) be made at a daily or weekly rate that is based on the type of room required.

58. **SCHEDULED ADMISSION OR SCHEDULED FOR ADMISSION** means a hospital admission of a Covered Person that a Physician has scheduled in advance by at least 24 hours.

59. **SICKNESS** is an illness or disease. It includes pregnancy and the resulting childbirth, miscarriage, Complications of Pregnancy, or abortion, except for a covered Dependent daughter, in which case Sickness does not include pregnancy, the resulting childbirth, miscarriage, Complications of Pregnancy, or abortion.

60. **THIRD PARTY ADMINISTRATOR** means the third-party administrator contracted by the Plan Sponsor to provide claims payment and administrative services for the Plan.

61. **WAITING PERIOD** is the time from the First Day of Employment until the Effective Date of Coverage.

62. **WORKING DAY** means any Monday through Friday, excluding national legal holidays.

Manatee County Government

Employee Benefit Plan

Plan Sponsor Certification

The Board of County Commissioners, Manatee County, Florida (the "County") sponsors the Manatee County Government Employee Benefit Plan (the "Plan"). Certain members of the County's workforce perform services in connection with administration of the Plan.

As sponsor of the Plan, the County acknowledges and agrees that the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), prohibit the Plan or its business associates from disclosing Protected Health Information (as defined in § 164.501 of the Privacy Standards) to members of the County's workforce unless the County agrees to the conditions and restrictions set out below.

To induce the Plan to disclose Protected Health Information to members of County's workforce as necessary for them to perform administrative functions for the Plan, the County hereby accepts these conditions and restrictions and certifies that the Plan documents have been amended to reflect these conditions and restrictions. The County agrees to:

a. Not use or further disclose Protected Health Information other than as permitted or required by the Plan Document or as required by law;

b. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the County with respect to such information;

c. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the County;

d. Report of the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by the Plan or required by law;

e. Make available Protected Health Information to individual Plan members in accordance with the Privacy Standards;

f. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with the Privacy Standards;

g. Make available an accounting of disclosures to individual Plan members in accordance the Privacy Standards;

h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

i. If feasible, return or destroy all Protected Health Information received from the Plan that the County still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible; and

j. Ensure the adequate separation between the Plan and members of the County's workforce, as required by the Privacy Standards the Plan's HIPAA Privacy Amendment.

IN WITNESS WHEREOF, the County has caused its duly authorized officer to set forth his signature as of this _____day of _____, _____.

BOARD OF COUNTY COMMISSIONERS

OF MANATEE COUNTY, FLORIDA

By: _____

Its: _____

ATTEST: ANGELINA COLONNESCO

By: _____

Clerk of the Circuit Court