Plan Document

for the

Board of County Commissioners

Manatee County, Florida

Employee Benefit Plan

Effective Date: January 1, 1994

Amended June 1, 2005

SCHEDULE OF BENEFITS

For persons eligible to be covered under

MANATEE COUNTY GOVERNMENT EMPLOYEE BENEFIT PLAN

Effective Date: January 1, 1994

Amended January 1, 1995, 1996, 1997

Amended July 1, 1997

Amended January 1, 2000

Amended January 1, 2004

Amended January 1, 2005

Amended June 1, 2005

Pending January 11, 2010

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

Constitutional Officers/Agencies: Board of County Commissioners

Clerk of Circuit Court

Housing Authority

Property Appraiser

Sheriff of Manatee County

Tax Collector

Supervisor of Elections

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 benefit plans terms and conditions are subject to change from time to time. The documents governing this Plan consist only of the Plan Document and this Summary Plan Description. No person or entity has any authority to make any oral changes or amendments to the Plan.

The Manatee Your Choice Health Plan is a Preferred Provider Plan (PPO). The Manatee Health Network is an exclusive managed care network providing medical, dental, and prescription drug services in Manatee, Sarasota, and nearby counties. Covered Health Services may be obtained either within the Manatee Health Network, other contracted Networks, 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.

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.You must show your ID card every time you request health care services from Network Providers.

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 your 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.

TERMINATION FOR FAILURE TO COOPERATE

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.

5. If a Covered Person fails to complete an Eligible Spouse and/or Child Eligibility Application, according to the rules of the Plan Document and all verification forms, will make the Dependents ineligible for coverage and will be obligated to refund any payments made by Manatee County Government's Medical/Dental Plan. The Covered Person's coverage will terminate upon thirty (30) days written notice.

6. All participating agencies in the Manatee Your Choice Health Plan are required to follow the BCC guidelines for employee participation; this includes the adoption that each employee contributes to the medical plan.

COST OF COVERAGE

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.

SECTION 1 - ELIGIBILITY AND ENROLLMENT

1.00. ENROLLMENT

1.00.01 Enrollment Date

The earlier of the date the person is enrolled under this Plan and the first day of the Waiting Period.

Waiting Period

The Waiting Period for coverage begins on the first day of full-time **active** employment and ends after 60 days of full-time **active** service. The Waiting Period is included in the Pre-Existing Condition Exclusion Period.

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 form;

-completing a Pre-Existing Condition Information form; and

-giving the forms to the Employer.

An Employee's enrollment is either timely or late.

-an Employee is considered a timely enrollee if he or she enrolls during either the Initial Eligibility Period or a Special Enrollment Period;

- an Employee is considered a late enrollee when he or she enrolls during the Open 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 form for each eligible Dependent;

-completing a Pre-Existing Condition Information form (19 and older only); and

-giving the forms along with proof of Dependent eligibility to the Employer.

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's enrollment is either timely or late.

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.

A Dependent is considered a late enrollee when he or she is enrolled for coverage during the Open Enrollment Period.

Enrollment Periods

The Initial Eligibility Period is the 60-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 to enroll for coverage to be effective the next designated Plan Year.

The Open Enrollment Period is in November each year. During this period, all eligible Employees and Dependents can enroll for coverage.

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 stated in writing, at the time coverage was previously offered that the other coverage was the reason for declining enrollment under this Plan.

-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 legal separation, divorce, death, 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.

Late Enrollees

A late enrollee can enroll only during an Open Enrollment Period. A late enrollee is also subject to the Pre-existing Condition Exclusion.

Retired Employees are not eligible to enroll as a late enrollee.

1.00.02 Effective Date of Employee Coverage

Employee Coverage is effective on the first day of the month coincident with or next following the latest

of:

-The Effective Date shown in the Schedule of Benefits.

-The date the Employee enrolls for coverage.

-The date the Employee completes a Waiting Period of 60 days of **Active** Service.

1.00.03 Effective Date of Dependent Coverage

Coverage for Initial Dependents, with Proof of Eligibility is effective on the first day of the month coincident with or next following the latest of:

-The date the Employee's coverage becomes effective.

-The date the Employee enrolls the Dependents.

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 so 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, the date the child becomes a Dependent.

1.00.04 Extended Benefits

There are extended benefits for Medical and Prescription Drug Benefits.

Extended benefits are payable for a Totally Disabled Covered Person for up to 6 months. Extended benefits are only payable for Covered Services and Supplies given during the 6 month period after the person's coverage ends.

The person must be continuously Totally Disabled due to the same cause from the date coverage ends until the date Covered Services or Supplies are given.

1.01ELIGIBLE PERSONS

1.01.01 EMPLOYEE COVERAGE

Employees are:

All full-time Employees, 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 are eligible for and receiving the periodic payment of benefits from the Florida Retirement System without penalty 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 living in the household of the 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. (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) An 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.

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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 the Plan Administrator the Plan's or 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 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, there will be no additional premium for coverage of the newborn child for the first 30 days of coverage. The applicable premium will be charged after the initial 30 days of coverage. If notice is not given within the 30 day period referenced above, the applicable premium will be charged from the date of birth.

1.01.03 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. PROOF OF ELIGIBILITY

An Employee must complete the Certification of Eligibility Application and provide the Documents requested in the application to the Plan Administrator.

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.

1.02. WAIVER OF COVERAGE

1.02.01 WAIVER OF EMPLOYEE COVERAGE

You may waive your coverage under the plan by signing a Waiver of Coverage Form. This form must be completed and approved by the Plan Sponsor. If you make such a waiver and then wish to 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.

1.02.02 WAIVER OF DEPENDENT(S) COVERAGE

You may waive coverage for your Eligible Dependents under the plan by signing a Waiver of Coverage Form. This form must be completed and approved by the Plan Sponsor.

If you make such a waiver 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) must also be enrolled in the Plan continuously for 12 months prior to the employee's last day of work to be eligible for Dependent enrollment.

The Employee must either:

-elect to receive FRS Benefits immediately in order to continue to participate in the employee and dependents' plans, or

-defer FRS benefits as allowed by Florida Law at the time of termination of employment, and still be eligible to apply for participation in the medical plan upon electing to receive FRS benefits at a later date. Employees must apply for medical benefits within 30 days of the Effective Date of FRS benefits.

1.03.01 Eligible Retiree Enrollment

Eligible Retired Employees and their Dependents must enroll in the Plan within 30 days after the effective date of the Retiree's retirement and pay a premium.

Eligible Retired Employees must complete a Manatee County Government Medical Enrollment Application and provide the following Proof of Eligibility at the time of enrollment:

-Certification of eligibility to receive FRS Benefits

-Proof of Medical Insurance or self-insurance without lapse of coverage of more than 63 days prior to reinstatement of Manatee County Government Coverage

-Evidence of Insurability is required if there is more than 63 days lapse between coverage periods.

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

A Retired Employee who was enrolled in the Plan prior to retirement may temporarily suspend enrollment one time if eligible for benefits under a new employer's Group Medical/Dental Plan if:

-Retired Employee is enrolled in the Plan

-There is no lapse in coverage between the inception and termination of Retired Employee's enrollment in the new employer's Medical/Dental Benefit Plan and his/her suspension and re-enrollment in the Plan

-The Retired Employee provides, when applicable, appropriate proof of coverage and termination of coverage from the new employer;

-A Retiree or Retiree Spouse electing to enroll in another County sponsored Medicare Supplement and Medicare D Prescription Plan may re-enter the County's Plan, prior to a new Plan Year Effective Date as a onetime only option for the next Open Enrollment Period.

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. PRE-EXISTING CONDITIONS LIMITATIONS

1.04.01 Pre-Existing Condition Exclusion

A pre-existing condition is an injury or Sickness which was diagnosed or treated or for which prescription medications or drugs were prescribed or taken within the three (3) month period ending on the person's Enrollment Date. A pre-existing condition does not include pregnancy. Genetic information is not an indicator of a pre-existing condition if there is not a diagnosis of a condition related to the genetic information.

1.04.02 Continuous Creditable Coverage.

Continuous creditable coverage is health care coverage under any of the types of plans listed below, during which there was a lapse in coverage of no more than sixty-two (62) days:

-A group health plan.

-Health insurance coverage

-Medicare

-Medicaid

-Medical and dental care for members and certain former members of the uniformed services and their dependents.

-The Federal Employees Health Benefits Program.

-A medical care program of the Indian Health Services or of a tribal organization.

-A state health benefits risk pool.

-A health benefit plan under the Peace Corps Act.

-Any public health benefit program provided by a state, county or other political subdivision of a state.

The Waiting Period under this Plan will be included in the period of time counted as Continuous Creditable Coverage when calculating the time periods during which the pre-existing condition exclusion is applied.

A Covered Person can show the Plan the length of Continuous Creditable Coverage in order to either shorten or eliminate the time period during which the pre-existing condition exclusion applies. Any or all of the plans that provided prior coverage must give the Covered Person a certificate of creditable coverage. If necessary, the Employer will help in obtaining this certificate of creditable coverage from a prior plan

1.04.03 Coverage for Pre-Existing Condition

No coverage is provided for the treatment of a pre-existing condition until the earlier of the following:

-the date the person has had Continuous Creditable Coverage for a period of three (3) months and has not received treatment for the pre-existing condition; or

-the date the person has had Continuous Creditable Coverage for six (6) months.

1.04.04 Exception to Pre-Existing Condition Exclusion

This exclusion does not apply to children under the age of 19.

1.05. 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 on account of and consistent with significant cost increases, significant cost decreases, 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 change in the residence of the participant, spouse or dependent;
- 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.

Whether or not an event constitutes a Change in Status is determined by the Plan Administrator, in its discretion.

- 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 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.

1.05.01 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.

1.05.02 AGE CHANGES

If Coverage terminates or reduces 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.

1.06. 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 in an Eligible Class; OR
5. the date your employment terminates; or, the date you are no longer scheduled to work.

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:

Reason You Stopped Active Work	Period Of Time
1. Leave of Absence under Family Medical Leave Act requirements	in accordance with FMLA
2. Authorized Leave of Absence	six months

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

1.06.01 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), 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.

1.07. TERMINATION FOR FAILURE TO COOPERATE

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 representatives 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.

5. If a Covered Person fails to complete an Eligible Spouse and/or Child Eligibility Application, according to the rules of the Plan Document and all verification forms, will make the Dependents ineligible for coverage and will be obligated to refund any payments made by Manatee County Government's Medical/Dental Plan. The

Covered Person's coverage will terminate upon thirty (30) days written notice.

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 in Manatee, Sarasota, Pinellas, Hillsborough, Hernando, Pasco, Charlotte, and Lee Counties and to 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 Manatee Health Network Providers and selected PPO Network(s) 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 will be reimbursed at a reduced level of reimbursement and/or higher level of Covered Persons' responsibility for payment as described in the Schedule of Benefits.

The Manatee Health Network fee is the level of reimbursement the Manatee Health Network 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.

The level of reimbursement for all other Covered Services and Supplies is no more than the Manatee Network Fee Schedule. The Covered Person is responsible to the Provider for the difference between the Manatee Network Fee Schedule and the billed amount.

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 toward Covered Services 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. An out-of-area vacation or county business is limited to fourteen (14) days without prior approval by the Plan Manager. 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.

Student Out of Area – Student attending an accredited school or on vacation, services will be paid at the Highest Level of Reimbursement according to their enrolled Plan at time of service.

2.03. PRE-CERTIFICATION FOR HOSPITALIZATION

a. You are responsible for pre-certifying your stay by contacting the Medical Management Department within seven (7) working days prior to a scheduled, non-emergency admission; or,

b. Within 24 hours (or next working day) following an Emergency Admission.

2.04. "*YOURCHOICE"* HEALTH PLAN

Approved in 2009 and effective January 1, 2011the Plan Document is amended to provide participants the choice to enroll in one of four Health Plans based upon completing specific Qualifying Events. The County Administrator is authorized to establish the Guidelines and Rules, Levels of Reimbursement and Qualifying Events for the "*YourChoice"* Health Plans.

2.04.01 "*YOURCHOICE*" PLAN DESIGN

The "*YourChoice*" Health Plans are:

- "*YourChoice*" Basic — Lowest Level of Reimbursement
- "*YourChoice*" Better — Middle Level of Reimbursement
- "*YourChoice*" 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 Manatee Health Network or Non-Manatee Health Network providers,
Choice to utilize or not to utilize Manatee Choice Guidelines, and
Choice to utilize the Member Advocacy Program.

2.04.02 "*YOURCHOICE*" GROUPS

There are two "*YourChoice"* Groups

- Adult Group includes Employee, enrolled Retiree, Covered Spouse and/or Dependent Student(s) Age 19 and over. Each Adult Member is enrolled in a *"YourChoice*" Health Plan depending upon completing the Plan's Qualifying Events.

- Child Group includes all Covered Dependent Children living in the same household of an employee (from birth to Age 19 as determined by the Plan Document.) All Children living in the same household are enrolled in the Health Plan as a Child Group.

2.04.03 "*YOURCHOICE*" QUALIFYING EVENTS

A Qualifying Event is a specific course of action to be completed by a Member to determine which "YourChoice" Health Plan the Adult Member or Family Child Group is enrolled in for the Plan Year until

the next Qualifying Event period. Qualifying is based on age according to Evidence Based 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.

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 "*YourChoice*" Health Plans are approved by the Board of County Commissioners and may be found in Section 3 of the Plan Document.

2.06. 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 Other Insurance

An Employee and/or a Dependent Spouse enrolled in another Medical Plan, except a Government Plan exempt by Federal Statute, is primary and the County's Plan is secondary.

2.08. New Employee Enrollment

All New Employees and Eligible Dependent(s) (Spouse and Children age 19 and over) are automatically enrolled in the Better Health Plan following the benefits waiting period., Enrollees will be eligible to qualify for the Ultimate, Best or Better Plan during a six months waiting period by completing all of the required Qualifying Events for the Ultimate, Best or Better Plan. The enrollees must submit the supporting documentation to Employee Health Benefits at least 30 days prior to the benefits effective date of the seventh month to be placed in the Ultimate, Best or Better Health Plan. Enrollees who do not complete any Qualifying Events during their six month waiting period will be placed in the Basic Plan effective the first day of the seventh month.

All New Employee's Covered Dependent Child(ren) under age 19
Dependent Child(ren) under age 19 will be automatically enrolled in the Better Health Plan. The Covered Dependent Child(ren) are eligible to qualify for the Ultimate ~~Best~~ Health Plan by completing the Child Qualifying Events and submit the supporting documentation to Employee Health Benefits at least 30 days prior to the benefits effective date of the seventh month to be placed in the Ultimate Health Plan. Dependent Child(ren) who do not complete any Qualifying Events will remain in the Better Plan

2.09. Family Status Change

An Employee adding eligible adult dependent(s) through a Family Status Change is/are eligible to qualify for the Better Health Plan by completing the Health Risk Assessment including lab work and Wellness Profile Exam within 30 days after the Benefits Effective. The added Dependent(s) are eligible to qualify for the Ultimate or Best Health Plan during the next Qualifying Event Period for the next Plan Year.

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

2.09.02 An employee adding a newborn to a Child(ren) Group will be automatically enrolled in the same Plan as the other Child(ren) within the eligible Family Group.

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

Carry Over – Plan Levels Basic, Better and Best– If the Deductible is satisfied in whole or in part by eligible expenses incurred during October, November or December, those expenses will apply to the Deductible applicable in the next Calendar Year.

Manatee Health Network - Levels of Reimbursement

Hospital Benefits	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
In-patient Hospital	Plan Pays 100%	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
In-Patient Surgery	Plan Pays 100%	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
Ambulatory Surgery Center	Plan Pays 100%	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
Individual Cost Sharing-Hospital				
Deductible per Confinement	None	$250	$250	$1,000
Coinsurance per Confinement	None	80%	75%	50%
Max. per Confinement Plus Deductible	None	$1,000	$1,200	$3,000

Physician and Ancillary Service	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Copay per Office Visit	$25	$25	None	None
Deductible	None	$250	$500	$1,000
Coinsurance After Deductible	None	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Annual Individual Out-of-Pocket	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Expense After Copay and Deductible Except In-Patient	$1,400*	$1,800*	$2,400*	$5,000*
X-ray and Labs	None	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Specialist Physician Office Visits Cardiology, Endocrinology, Oncology, Infectious Disease	$25 Co-pay first 5 Visits per Calendar Year per specialty, then no co-pay	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
OBGYN - Maternity Only	$100 per Initial visit per pregnancy and 100% thereafter	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
GYN- Non Maternity	$25 Co-pay	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
GYN-Wellness Profile	No Co-pay	No Co-Pay	No Co-pay	No Co-pay

	ULTIMATE	BEST	BETTER	BASIC
Urgent Care Center	$25 Co-pay per Visit	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Emergency Room Facility* Physician Services Per Visit				
Copay/Deductible*	$100 per Visit	$150 per Visit	$200 per Visit	$300 per Visit
Coinsurance*	None	80% after Copay, Deductible Met	75% after Copay, Deductible Met	50% after Copay, Deductible Met
*Copay, Deductible, and Coinsurance waived if admitted w/in 24 hours and stay is longer than 24 hours.				
Ancillary Services Radiology, MRI, Cat Scans Ambulatory Surgery Center, Ambulance Services, Laboratory Emergency Air Transport to the nearest hospital that can provide the appropriate treatment for the Emergency condition.	100% Covered Without Co-pay	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Alternate Care Benefit **Per Each Alternate Care Benefit**	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Maximum Annual Benefit*	$750	$750	$750	$750
Acupuncture*				
Copay Per Visit	$25	----	-----	----
Co-insurance	None	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Chiropractic Services* Including Spinal Manipulation				
Copay per Visit	$25	----	----	----
Co-insurance	None	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Massage Therapy (Physician Ordered)				
Copay per Visit	$25	----	----	----
Co-Insurance	None	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Physical Therapy - Level 1 and 2*	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Copay: Level 1 Level 2	$0-visits 1-5 $25/visit beyond $25 per visit	-----	-----	-----
Coinsurance	None	80% after Deductible	75% after Deductible	50% after Deductible
Pre-Certified by Medical Management	Yes	Yes	Yes	Yes

Occupational Therapy **	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Copay Per Visit	$25	------	------	------
Co-insurance	None	80% after Deductible	75% after Deductible	50% after Deductible
Speech Therapy **				
Copay per Visit	$25	------	------	------
Co-insurance	None	80% after Deductible	75% after Deductible	50% after Deductible
Pre-Certified by Medical Management	Yes	Yes	Yes	Yes
Nutritional Therapy-Registered Dietician				
Copay	$0 for visits 1-5, $25 all visits thereafter	------	------	------
Coinsurance	None	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Other Benefits	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Skilled Nursing and/or Acute Rehabilitation Facility				
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	90%	80% after Deductible	75% after Deductible	50% after Deductible
Pre-Certified by Medical Management	Yes	Yes	Yes	Yes
Home Health Care Network Contracted Rate				
Maximum Annual Benefit	The greater of 120 Days or $1,000	The greater of 120 Days or $1,000	The greater of 120 Days or $1,000	The greater of 120 Days or $1,000
Coinsurance	None	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Pre-Certified by Medical Management	Yes	**Yes**	**Yes**	Yes
Rehabilitation Out Patient Facility Maximum $25,000 annually Network Contracted Rate	100% Covered	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Hospice – Licensed Facility	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Maximum Life Time Benefit	$50,000	$50,000	$50,000	$50,000
Inpatient Care	100% Contracted Rate	100% Contracted Rate	100% Contracted Rate	100% Contracted Rate
Pre-Certified by Med. Mgmt	Yes	Yes	Yes	Yes

Durable Medical Equipment	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Purchase after Initial Rental Period– Amount above $500 must be Pre-certified	90%-Plan Pays	80% after Deductible met	75% after Deductible Met	50% after Deductible Met
Rental	90%-Plan Pays	80% after Deductible met	75% after Deductible Met	50% after Deductible Met
Repair	50%-Plan Pays	50% after Deductible Met	50% after Deductible Met	25% after Deductible Met
Pre-Certified by Medical Management	Yes	Yes	Yes	Yes
One Pair of Diabetic Shoes per Year according to Contracted Rate	90%-Plan Pays	80% after Deductible met	75% after Deductible Met	50% after Deductible Met
Orthotics	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Foot-custom molded Oral-Sleep Apnea Contracted Network Rate	50% of Contracted Rate	50% after Deductible	50% after Deductible	50% after Deductible
Other Orthotics	90% Plan Pays	80% after Deductible	75% after Deductible	50% after Deductible
Surgical Supplies Network Contracted Rate	80% of Contracted Rate	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Vision Care - Adult	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Routine Eye Exam - Every two Years (Glasses)	$25 Copay for Exam Only	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Eye Exam - Every Year (Contact Lens)	$25 Copay for Exam Only	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Refractions	Not a Covered Expense	Not a Covered Expense	Not a Covered Expense	Not a Covered Expense
Diabetic – 1 Exam per year	No Copay	No Copay	No Copay	No Copay
Eye Exam - Medical Condition	$25 Copay	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Refractions – with Pre-Cert	A Covered Expense	A Covered Expense	A Covered Expense	A Covered Expense
Cataract Surgery - Glasses	100%	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Allergy Testing & Treatment	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Allergy Testing	$25.00 copay, Then 100%	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Allergy Treatment-Adult (including serum)	$7.00 copay, then 100%	80% after Deductible Met	75% after Deductible Met	50% after Deductible Met
Allergy Treatment-Child (including serum)	$3.00 copay, then 100%	NA	75% after Deductible Met	N/A
Healthy Habits – Preventive & Wellness	No Copay	No Copay	No Copay	N/A
Child Preventive Dental Program Prophylaxis, Radiology, Restorative	No Copay	NA	No Copay	N/A
Child Annual Exam & Immunizations	No Copay	NA	No Copay	N/A

Non-Manatee Health Network - Levels of Reimbursement

Hospital Benefits	**ULTIMATE PLAN**	**BEST PLAN**	**BETTER PLAN**	**BASIC PLAN**
In-patient Hospital	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
In-Patient Surgery	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
Ambulatory Surgery Center	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.	Ded. & Coin.
Individual Cost Sharing				
Deductible per Confinement	$250	$750	$1,000	$2,000
Coinsurance per Confinement after Deductible Paid	80%	80%	75%	50%
Max. per Confinement Plus Deductible	$2,800	$3,200	$3,600	$5,000
Physician and Ancillary Service	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Individual Cost Sharing Copay per Visit	None	None	None	None
Deductible	$500	$750	$1,000	$2,000
Coinsurance After Deductible Paid	80%	80%	75%	50%
Annual Out of Pocket Expense After Deductible*	$2,800*	$5,000*	$7,200*	$10,000*
	ULTIMATE	**BEST**	**BETTER**	**BASIC**
Primary Care Physicians and Specialty Physicians including office visit minor surgery, x-ray and lab	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
OBGYN - Maternity Only	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
GYN- Non Maternity	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
GYN-Wellness Profile	Not Available	Not Available	Not Available	Not Available
Urgent Care Center	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
Emergency Room & Physician Services Per Visit				
	ULTIMATE	**BEST**	**BETTER**	**BASIC**
Copay, deductible Coinsurance	$250 per Visit 80% after Deductible	$350 per Visit 80% after Deductible	$500 per Visit 75% after Deductible	$750 per Visit 50% after Copay, Deductible
Copay, Deductible and coinsurance waived if admitted w/in 24 hrs and stay is longer than 24hrs.				
Co-pay or deductible does not apply to out of pocket expense.				
Ancillary Services Radiology, MRI, Cat Scans Ambulance Services, Laboratory, Emergency Air Transport to the nearest hospital that can provide the appropriate treatment for the emergency condition.(Precert)	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible

	ULTIMATE	BEST	BETTER	BASIC
Ambulatory Surgical Center	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
Alternate Care Benefit * Per Each Alternate Care Benefit				
	ULTIMATE	**BEST**	**BETTER**	**BASIC**
Maximum Annual Benefit*	$750	$750	$750	$750
Acupuncture*	Not Available	Not Available	Not Available	Not Available
Chiropractic Services* including Spinal Manipulation and Massage Therapy* Coinsurance	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
Physical Therapy - Level 1* Coinsurance	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
Occupational Therapy* Co-insurance	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
Speech Therapy* Coinsurance Precertified by Med. Mgmt	80% after Deductible Yes	80% after Deductible Yes	75% after Deductible Yes	50% after Deductible Yes
Skilled Nursing and Acute Rehabilitation Facility	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Maximum Annual Benefit-	60 Days	60 Days	60 Days	60 Days
Days 1-20 Days 21-60 Copay/Coinsurance	$200 per day 80% after Deductible	$200 per Day 80% after Deductible	$200 per day 75% after Deductible	$200 per day 50% after Deductible
Pre-Certified by Medical Management	Yes	Yes	Yes	Yes
Home Health Care	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Maximum Annual Benefit	The greater of 120 days or $1,000	The greater of 120 days or $1,000	The greater of 120 days or $1,000	The greater of 120 days or $1,000
Coinsurance	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
	ULTIMATE	**BEST**	**BETTER**	**BASIC**
Rehabilitation Out Patient Facility Maximum $25,000 annually	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible

	ULTIMATE	BEST	BETTER	BASIC
Hospice-Licensed Facility				
Maximum Life Time Benefit	$50,000	$50,000	$50,000	$50,000
Outpatient Daily Maximum	$125	$125	$125	$125
Inpatient Care	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
Pre-Certified by Medical Management	Yes	Yes	Yes	Yes
Durable Medical Equipment				
Purchase after Initial Rental Period– Amount above $500 must be Pre-certified	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
Rental	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
Repair	50% after Deductible	40% after Deductible	30% after Deductible	25% after Deductible
Pre-Certified by Medical Management	Yes	Yes	Yes	Yes
Orthotics – Foot-Custom Molded Oral-Sleep Apnea	50% of UCR after Deductible	50% of UCR after Deductible	50% of UCR after Deductible	50% of UCR after Deductible
Other Orthotics	80% after Ded.	80% after Ded.	75% after Ded.	50% after Ded.
Surgical Supplies	80% of UCR	80% of UCR	75% of UCR	50% of UCR
Eye Exam - Medical Condition	80% after Deductible - Exam Only	80% after Deductible - Exam Only	75% after Deductible - Exam Only	50% after Deductible - Exam Only
Refraction	Not a Covered Expense	Not a Covered Expense	Not a Covered Expense	Not a Covered Expense
Cataracts	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
Diabetic Vision – Optometrist, ophthalmologist	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
Allergy Testing & Treatment	**ULTIMATE**	**BEST**	**BETTER**	**BASIC**
Allergy Testing	80% after Deductible	80% after Deductible	75% after Deductible	50% after Deductible
Allergy Treatment-Adult (including serum)	$12.00 copay, then 80% after Deductible	$12.00 copay, then 80% after Deductible	$12.00 co-pay, then 75% after Deductible	$12.00 co-pay, then 50% after Deductible
Allergy Treatment-Child (including serum)	$12.00 Copay, then 80% after Deductible	N/A	$12.00 co-pay, then 75% after Deductible	N/A
Healthy Habits – Preventive & Wellness	Not Available	Not Available	Not Available	Not Available
Child Preventive Dental, Annual Exam and Immunizations	Not Available	Not Available	Not Available	Not Available

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 Medical 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 Medical 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, acupuncture, lifestyle coaching, holistic medicine, from Manatee Health Network Providers.

Ambulatory Surgical Center Services

A Center's services given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

Anesthetics

A covered expense according to negotiated fees.

Chemotherapy

Must be pre-certified by Medical Management

Children’s Dental Services

Preventative Dental Services provided for children (under the age of 19) are diagnostic, radiographs, test and laboratory exams, preventive procedures, space maintainers (children 13 or younger) and restorative procedures according to American Dental Codes updated annually.

1 routine dental exam in a consecutive twelve (12) month period.

1 prophylaxis in any six (6) consecutive month period

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 period

Dental fillings according to fee schedule

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.

Lifestyle Assistance Program for Life Threatening Conditions

See Section 8-Treatment for Behavioral Health for benefit coverage.

Dental Anesthesia and Hospitalization

Hospitalization services and 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 not a consumable or disposable item.

It is used primarily for a medical purpose.

It is appropriate for use in the home.

Some examples of Durable Medical Equipment are:

Appliances which replace a lost body organ or part or help an impaired one to work.

Orthotic devices such as arm, leg, neck and back braces.

Hospital-type beds.

Equipment needed to increase mobility, such as a wheelchair. Respirators or other equipment for the use of oxygen, monitoring devices.

Durable Medical Equipment greater than $500 must be pre-approved by Medical Management.

Foot Care

Care and treatment of the feet, if needed due to severe systemic disease. Routine care such as removal of warts, corns, or calluses, the cutting and trimming of toenails, foot care for flat feet, fallen arches, and chronic foot strain is a Covered Service only if needed due to severe systemic disease.

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:

Temporary or part-time nursing care by or supervised by a registered nurse (R.N.or LPN).

Physical therapy. Occupational therapy. Speech Therapy.

Covered Services are limited to one (1) visit per day for a maximum of one hundred and twenty (120) visits or $1,000 of services whichever is greater, 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 Medical Management is required for all Home Health Care Services.

Hospice Care

Room and Board.

Other Services and Supplies.

Part-time nursing care by or supervised by a registered nurse (R.N.).

Counseling for the patient and Covered Family Members.

Bereavement counseling for Covered Family Members. Services must be given within six (6) months after the patient's death. Covered Services are limited to a total of fifteen (15) visits for each family. Counseling must be given by a Licensed Counselor.

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.

Any counseling services given in connection with a terminal illness will not be considered as Mental Disorder Treatment.

Prior approval by Medical 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.

Emergency room services are covered only if it is determined that the services are Covered Health Services and there is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of emergency room services. If the Company, at its discretion, determines that a less intensive or more appropriate treatment could have been given then no benefits are payable.

When Emergency Care results in a confinement, the Covered Person (or representative or Physician) must call Medical Management within two working days of the date the confinement. It may not be reasonably possible to notify Medical Management within two working days. In this case, Medical Management must be notified as soon as reasonably possible.

When Emergency Care has ended, a referral from Medical Management, when applicable, is required before any additional services are received.

Laboratory Tests and X-rays

X-rays or tests for diagnosis or treatment

Mammography

One baseline mammogram at age 35

One mammogram every two years for ages 40 through 49.

One mammogram annually for ages 50 and older.

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 Supplies

Oxygen, Blood or blood derivatives only if not donated or replaced, casts, splints, trusses, crutches and surgical dressings; f needles and syringes;

Surgical supplies (such as bandages and dressings) when applied by a licensed medical professional.

Medical Transportation Services

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

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

These services must be given 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 acting within the scope of that license or certification.

Orthotics

Orthotics must be medically indicated and the result of illness or injury due to a covered condition.

Covered conditions for Orthotics limited to paralysis, spasticity, fracture, scoliosis or spinal surgery, diabetes, peripheral vascular disease and plantar fasiittis.

Repair and/or replacement will be reviewed by Medical Management if the orthotic is at least three (3) years old.

Bio electronic or computerized components are approved only by Medical Management.

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

Osteoporosis Diagnosis and Treatment

Services for the medically necessary diagnosis and treatment of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

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 regiment approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.

The therapy must be expected to result in significant, objective, measurable function improvement in the Covered Person's independence in ADLS 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 must be 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 (cerebral vascular accident).

Brain damage due to accidental injury or organic brain lesion (aphasia). Accidental injury.

The therapy must be 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.

Covered Services are limited to twenty (20) visits each Calendar Year and must be pre-approved by Medical Management.

Outpatient Speech Therapy for Children Under Age 4

Services of a licensed speech therapist for treatment given to a child under age 4 whose speech is impaired due to one of the following conditions and pre-approved by Medical Management:

Infantile autism.
Developmental delay or cerebral palsy. Hearing impairment.

Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

Covered Services are limited to twenty (20) visits each Calendar Year.

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 to improve the function of a malfunction is the direct result of one of the following:

Birth defect.

Sickness.

Surgery to treat a Sickness or accidental injury.

Accidental injury.

Reconstructive breast surgery following a necessary mastectomy.

Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to Sickness or accidental injury.

Cosmetic procedures are excluded from coverage. Procedures that correct a congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Assistant Surgeon Services

Covered Expenses for assistant surgeon services are limited to 1/5 of 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.

Pre-Admission Testing

Tests must be:

-made within four (4) days prior to confinement as an Inpatient; and

-related to the condition for which the Covered Person is being confined; and

-ordered by a Physician.

Prescribed Drugs and Medicines

Prescribed drugs and medicines for inpatient services.

Prosthetics

Prosthetics must be medically indicated and the result of illness or injury due to a covered condition.

Covered conditions for Prosthetics for the initial breast prosthetic to replace a breast surgically removed with replacement of two (2) each Prosthetics every two years while covered.

Covered conditions for Prosthetics limited to the initial limb prosthetics following amputation while covered.

Consideration may be given to replacement of prosthetic no longer functional as determined by the treating physician, only if the initial was obtained while covered.

Prosthetics greater than five hundred ($500.00) require precertification by Medical Management.

Radiation Therapy – Medical Management notification required

Reconstructive Surgery Following Mastectomy

Reconstruction of the breast on which the mastectomy has been performed due to breast cancer; and/or

Surgery and reconstruction of the other breast to produce a symmetrical appearance; and,

Prostheses and physical complications of all stages of mastectomy, including lymph edemas;

in a manner determined in consultation with the attending physician and the patient or according to the state statute where the service is performed.

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.

Medical Management authorization required.

Outpatient

Services of a Hospital or Comprehensive Outpatient Rehabilitative Facility (CORF) 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 Hospital or CORF in anyone 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:

From age <20-49, or evidence-based guidelines these tests are recommended:

* Cholesterol Levels

* Pelvic Exam (women)

* Breast Exam (women)

* Baseline Mammography (women) (35)

* Blood Glucose Levels

At age 50, there are additional tests recommended:

* Occult Blood in Stool

* Electrocardiogram

* Mammography (women)

*Colonoscopy according to AMA guidelines

Second Surgical Opinion

When surgery is advised, a Covered Person may get a Second Opinion to confirm that surgery is needed. Benefits for the Second Opinion will be payable for Covered Comprehensive Medical Charges incurred, for such Second Opinion, on an Outpatient basis, but only for:

1. Physician's Charges; and

2. related tests.

The Physician who provides the Second Opinion must be one who:

1. treats the type of condition for which surgery is advised; and

2. is not scheduled to do the surgery; and

3. has no business or financial relationship with the Physician recommending or performing the surgery.

If the second Physician disagrees with the first Physician, benefits will be payable for the cost of a Third Opinion, subject to the conditions listed above.

The Plan recommends a member to obtain a Second Surgical Opinion on the following procedures.

Submucous Resection (Deviated Septum)	Hysterectomy
Mastectomy	Spinal or Vertebral Surgery (Laminectomy)
Coronary Artery Bypass	Varicose Vein Removal/Stripping
Joint Replacement Surgery	Prostatectomy

Spinal Manipulations

Services of a Physician given for the detection or correction (manipulation by manual or mechanical means of structural imbalance or distortion in the spine.

Vision Screening and Treatment

Vision Exam related to a medical condition.

Initial contact lenses or glasses required following cataract surgery.

One regular Vision Care Exam every two (2) years.

One Contact Lens Exam annually.

Children – eye exam annually (up to age 19)

SECTION 4- HEALTH AND LIFESTYLE MANAGEMENT PROGRAM

The Center for Health and Lifestyle Management Incentive Program's goals are to develop awareness and educational values through Manatee Your Choice while instituting accountability on the part of the member to live a healthier lifestyle.

To accomplish the goal in some incidences incentives are made available to participants.
The Health and Lifestyle Management Program including Qualifying Events Incentive Program (Health Bucks) 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 www.ManateeYourChoice.com or from Employee Health Benefits.

5-LIMITED COVERED EXPENSES

Program and charges listed in Section 5 are payable upon approval of Medical Management according the Plan Guidelines. The Plan pay benefits based upon the *Your Choice* Health Plan the Member is enrolled in on the date of service.

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) on date of service. Services must be pre-approved by Medical Management.

5.00. TRANSPLANTS

a. cornea transplants;

b. artery or vein transplants;

c. kidney transplants;

d. pancreas;

e. heart transplants;

f. heart and lung transplants;

g. liver transplants;

h. heart valve transplants;

i. implantable prosthetic lenses in connection with cataracts;

j. prosthetic by-pass or replacement vessels;

k. bone transplants;

l. skin transplants.

Also covered are charges in connection with BONE MARROW TRANSPLANTS, including chemotherapy if chemotherapy is an integral part of the treatment involving the Bone Marrow Transplant, if recommended by the referring Physician and the treating Physician, and if the procedure follows the rules adopted by the Secretary of Health and Rehabilitative Services.

Human blood precursor cells may be obtained from the Covered Person in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, circulating blood or bone marrow and circulating blood.

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. The total of the donor's and the donee's charges will not be more than any maximums under this Plan applicable to the donee.

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. The total of the donor's and the donee's charges will not be more than any maximums under this Plan applicable to the donee.

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:

a. within 12 months after and as the result of an injury; and,

b. for the correcting of a congenital defect of a covered Dependent child, provided the child was covered under the Plan Sponsor's Plan from birth; and,

c. for replacement of diseased tissue surgically removed.

5.02. SLEEP DISORDER BENEFITS

The Plan covers consultation and diagnostic testing for sleep apnea, a temporary cessation of breathing during sleep and or airway obstruction. Sleep Apnea's primary cause is the collapse of the upper airway level of the pharynx opening. Sleep disorder benefits are only paid when provided by a Manatee Health Network Provider and pre-approved by Medical Management. Benefits are paid according the participant's enrolled Plan Level on date of service.

CONSULTATION AND DIAGNOSTIC TESTING

The benefit includes one (1) Sleep Study within a 12 month period at an approved and licensed facility in the state which performed. Prior approval for the sleep study is required.

MAXIMUM ANNUAL BENENFIT – CONULTATIONS AND DIAGNOSTIC SERVICES

The Plan will pay a Maximum Annual Benefit, after Co-pays or deductible for consultations, diagnostic testing, and medical services including hospital and hospital services when services are performed by a Manatee Network Provider.

Annual Maximum Physician Benefit……According to the Level of Reimbursement up to $1000

CO-PAY, CO-INSURANCE AND DEDUCTIBLE

Manatee Choice pays according to the Level of Reimbursement

Copay, Co-Insurance and Deductible does not apply to the out of pocket.

LIMITATIONS CONSULTATIONS AND DIAGNOSTIC TESTING

A Manatee Health 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 Manatee Health Network Provider upon approval or Utilization Management. Prior to authorization for surgery attempts at conservative therapies must be tried for 6 months to include weight reduction, if applicable. Physician documentation of failure is required. Weight reduction must be attempted if applicable.

FACILITIES FOR SLEEP DISORDER TESTING

Sleep disorder test annual maximum facility benefit……Determined by contractual agreement

The Plan pays for a second Sleep Disorder Test when requested by a physician within 60 days of initial test, and must be supported by necessary documentation and approved by Medical Management.

5.03. TEMPOROMANDIBULAR DISORDERS (TMJ)

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

Treatments following diagnosis of TMJ when pre-approved by Medical Management.

* Behavior change- Therapy to learn how to eat properly

* Moist heat compress- Physical or Massage Therapists/Chiropractic

* Exercise-Physical or Massage Therapists/Chiropractic

* Oral Medications- Prescribed by Primary Care Physician and obtained through County's Prescriptions Plan

*Oral Appliance-Prescribed by Provider

Surgery for TMJ when pre-approved by Medical Management and

* if the range of mandibular motion is outside normal limits; and,

* if conservative treatment listed above were utilized and failed; and,

* when no more conservative treatment may be required prior to approval of surgery; and

* a second surgical opinion verifying the need for surgery has been obtained.

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

See 3.00 Schedule of Benefits

5.06. BARIATRIC SURGERY

The Plan pays for Bariatric Surgery only according to Medical Management guidelines. For information contact Medical Management.

The Member requesting Bariatric Surgery must:

- be pre-certified by Medical Management;
- be pre-approved by Medical Management that all the Guidelines are complete and
- utilize a Manatee Health Network provider or another approved provider when the Member lives outside of the Manatee Health Network area.

The Plan pay benefits based upon the "*YourChoice*" Health Plan the Member is enrolled in on the date of service.

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.
    b. The Member Advocacy Program (**MAP**) department is responsible for authorizing pain management injections and other invasive procedures.
    c. Failure to obtain approval could result in denial of payment for services.

2. Prior Authorization for Pain Medications
    a. Prior authorization is required for selected pain medications
    b. Quantity limitations apply to selected pain medications as established by the Manatee Your Choice Health Plan and the Clinical Pharmacist
    c. Prior authorization is required for selected pain medications when the prescribed quantity exceeds the listed quantity limits.

SECTION 6-MEDICAL MANAGEMENT

6.00 MEDICAL MANAGEMENT PROGRAM

The Medical Management Program (MMP Program) is a program administered by the Plan's Member Advocates. It provides Pre-admission review, Concurrent Review, and Discharge Planning on Hospital Admissions, Prescription, Medical Management, Preventive Care and Wellness.

Inpatient confinements:

All confinements of 3 days or more, and all out of network referrals
All ICU confinements
Skilled nursing facility
Rehabilitation facility
Pregnancies (for notification please call after the first prenatal visit)
All Behavioral Health hospitalizations

Reconstructive procedures and procedures that may be considered cosmetic:

Blepharoplasty
Botox injections
Breast Reconstruction
Excision of excess skin due to weight loss
Rhinoplasty
Sclerotherapy or surgery for varicosities (codes 36475-36479)
Other Cosmetic Surgery as covered by the plan document

Surgical Procedures:

Bariatric Surgery (Roux-en-Y and Lap Band)
Elective spinal surgeries
All implantable stimulators and pumps
Uvulopalatopharyngoplasty, including laser-assisted procedures
Any TMJ surgery/appliances
Any surgery over 3 day length of stay anticipated

Selected durable medical equipment:

All equipment greater than $500.00
All prosthetics
C-PAP or BI-PAP equipment
Any type of orthotic greater than $500.00

Specialty Medications and Infusion Services:

All injectables: office, outpatient and home administration
Pain Management pumps
Infusion Services: office, outpatient, or home administration

Outpatient Services:

Ambulance transfers between facilities
Chemotherapy and Radiation therapy
Hospice Services
Home Health Services: limited to the greater of 120 visits or $1,000 per calendar year
Invasive Pain Management Procedures
Sleep Studies

Speech Therapy
PET scans
SmartPill Capsule Motility (CPT 91299)
Refractions for diseases related to the eye
All Behavioral Health services

Pre-Admission Review- review is performed for admissions for Scheduled procedures, prior to admission.

Concurrent Review- review is performed for Scheduled and Non-Scheduled Admissions during confinement

Discharge Planning- where necessary, arrangements are made to facilitate the earliest dismissal possible.

Charges that are determined by Medical Management not to be Medically Indicated are not Covered Comprehensive Medical Charges, and no benefits will be paid for such charges.

6.01SCHEDULED ADMISSIONS

When a Covered Person is Scheduled for Admission to any Hospital over 3 days or as a result of a diagnosis requiring authorization, notification of the need for certification must be received by Medical Management prior to Hospital Admission. This may be done by:

a. Telephoning the Medical Management.

b. Completing a Pre-Admission Review Request form when applicable; or

c. Having the admitting Physician contact the Medical Management.

The responsibility of notifying Medical Management lies with the Covered Person. Individuals are advised to contact the Medical Management directly to verify that the admitting Physician or Hospital has made "notification".

The following information is necessary for notification:

a. Plan Sponsor's name and Plan number; and

b. Employee's name/Medical Identification Number/Social Security Number; and

c. Patient's name and date of birth; and

d. Physician's name/phone number; and

e. Hospital's name/phone number; and

f. Date of Admission; and

g. Diagnosis/Planned Procedure.

6.01.01 NON-SCHEDULED ADMISSIONS

When a Covered Person is admitted to any hospital on a Non-Scheduled basis, Medical Management must be notified as soon as is reasonably possible if the admission is to an ICU service or if the Hospital stay exceeds three days. Failure to provide notification within the above guidelines will result in application of the Additional Per Confinement Deductible or increased amounts payable by the Covered Person

6.01.02 NON-PREAPPROVED NOTIFICATION

Failure to provide notification within 72 hours (3 days not including Saturday and/or Sunday) from the time of inpatient admission or outpatient care will result in application of:

1) Confinement deductible of $200 per day

2) Outpatient office visit of $25 additional co-pay per visit in addition to the deductible, coinsurance and/or co-pay and not included in the annual maximum out of pocket expense.

6.01.03 MATERNITY BENEFITS

Medical Management must be notified during the first trimester. 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 in excess of 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.

6.01.04 OTHER

For all other Covered Services requiring pre-certification, Medical 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 or not 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. Which was 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 and as provided under Child Health Supervision Services Benefits
7. Injuries or illness due to war, or any act due to war, if declared or not; or
8. Except as specifically provided under Covered Services and Supplies: eye refractions; eye glasses or the fitting of eye glasses; radial keratotomy; visual training; vision therapy, speech therapy; hearing aid or the fitting of hearing aids; shoes; or
9. Diagnosis and treatment of weak, strained, flat feet, metatarsalgia, bunions, calcaneal bursitis, painful feet, inflamed feet or the cutting or removal of corns, callous and toenails. (This does not apply to the removal of nail roots); or
10. Educational testing or training; or treatment of developmental delay or
11. Custodial Care; or
12. Private Duty Nursing Care; or
13. Sleep Disorders and the testing of Sleep Disorders except as specifically provided in the Plan; or
14. Plasmapheresis for the treatment except for accepted condition; or
15. Charges incurred as a donor of an organ when the donee is not covered under this Plan; or
16. Drugs and medicines, whether prescription or non-prescription, with the exception of Norplant (all other prescription drugs are provided under a separate Plan Benefit); or
17. Charges that are more than the Reasonable and Customary Charges at the 75th percentile for the services and supplies furnished; or
18. Hospital services and supplies when confinement is solely for diagnostic testing purposes; or
19. In vitro fertilization; infertility; embryo transfer procedures; artificial insemination; sex-change surgery; reversal of sterilization; or charges for birth control, injectables, .
20. 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.
21. Care, treatment, services or supplies not prescribed by a Physician; or not Medically Indicated and/or evidence-based necessary; or which are experimental as recognized in the United States.

(This will not apply to Bone Marrow Transplants if recommended by the referring Physician and the treating Physician, and if the procedure follows the rules adopted by the Secretary of Health and Rehabilitative Services); or

22. which are provided mainly for the purpose of medical or other research; or

23. which were received from a nurse but which do not require the skill or training of a nurse; or

24. which were payable under other provisions of this Plan; or

25. 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

26. 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

27. 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.

28. Charges for services received as a result 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.

29. Any loss due to an intentionally self-inflicted Injury, while sane or insane.

30. Nutritional Supplements.

31. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

32. Exercise programs for treatment of any conditions, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

33. 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.

34. 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.

35. 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.

36. Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances.

37. Meridian Therapy (Acupuncture) unless performed by a Physician or licensed Acupuncturist.

38. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

39. Charges incurred for which the Plan has no legal obligation to pay.

40. 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.

41. Services, treatments and supplies which are not specified as covered under this Plan.

42. Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another disease unless specifically covered in the Schedule of Benefits. Medically Indicated charges for Morbid Obesity will be covered. Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life

Insurance Co. Tables for a person of the same height, age and mobility as the Covered Person.

43. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies, lift chairs, and non-hospital adjustable beds.

44. Charges excluded by the Plan Design. as

45. Replacement of braces of the leg, arm, back, neck or artificial arms or legs, unless there is sufficient 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.

46. 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.

47. Care and treatment for reversal of surgical sterilization.

48. Care and treatment for tobacco cessation programs, including smoking deterrent patches, unless Medically Indicated due to a severe active lung illness such as emphysema or asthma, unless such care is specifically covered in the Schedule of Benefits.

49. Charges for travel or for travel outside the United States or its territories or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

50. Care and treatment charges for Autologous Chondrocyte.

51. 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 shall be excluded if the Covered Person is discharged against medical advice, even if such charges are incurred prior to such discharge.

52. Genetic testing without evidence of symptomatology.

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

The *YourChoice* Health Plan provides separate Benefits for Plan Members requiring the Treatment of Behavioral Health and Substance Abuse services. Your Choice is exempt from following Mental Health Parity Act per Federal regulations as a self funded non-federal governmental entity.

8.00.01 PLAN DESIGN

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

Behavioral Health Services that are provided by the Manatee Health Network providers in Manatee, Sarasota, Pinellas and Hillsborough Counties will paid at the Highest Level of Reimbursement.

Behavior Health Services provided by a Non-Manatee Health Network Provider are paid at a Lower Level of Reimbursement.

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

The Lifetime Benefits for Behavioral Health and Substance Abuse Services is included in the Medical Plan's Total Lifetime Benefits.

8.00.02 SCHEDULE OF BEHAVIORAL HEALTH BENEFITS

LAMP (Lifestyle Assistance and Modification Program) is a comprehensive approach for the support of our members who require counseling for stress and coping skill development that may impact medical/health conditions, work productivity and interpersonal relationships. LAMP assists members to meet the everyday challenges that impact their quality of life at home, work and in the community.

LAMP benefits are identical regardless of enrollment in the Basic, Better, Best or Ultimate Plan.

Pre-Approval for Services	**All Behavioral Health Services (In and Out of Network) must be pre-approved by the Plan's LAMP in order to receive benefits at the highest level of reimbursement. Allowable charge is reduced by 50% for non-precertification**
Office Visits per Calendar	**42 combined Counseling and Psychiatry visits**

	OUTPATIENT COUNSELING	**PSYCHIATRIC SERVICES**
MANATEE SERVICE CENTER		
Co-payment	Five (5) visits with no co-pay-per calendar year. $15 co-pay starting with the 6th visit.	1st visit with no co-pay. $15 co-pay starting with the 2nd visit
Deductible	None	None
Coinsurance	None	None
Group Therapy	One time $25 co-pay	NA
MHN BENEFITS		
Co-payment	Five (5) visits with no co-pay-per calendar year. $25 co-pay starting with the 6th visit.	$25 co-pay each visit
Deductible	None	None
Coinsurance	None	None
Group Therapy	$25 per Session	NA
Group Sessions per calendar year	24 Sessions	N/A
OUT OF NETWORK BENEFITS		
Co-payment	None	None
Deductible	$200 per calendar year*	$200 per calendar year*
Coinsurance	60/40% after deductible	60/40% after deductible
Group Therapy	$35.00 per session	NA
Group sessions per calendar year	24 Sessions	NA
Maximum Out of Pocket Expense after Deductible	$3600 per Individual* $7,200 per Family*	$3,600-Individual *

***Combined total for Lifestyle Coaching and Psychiatry**

INTENSIVE MENTAL HEALTH BENEFITS

Precertification	Required for MHN & Non MHN Penalty-$500 per admission for non pre-certification-Must be obtained within 72 hours of admission.	
MHN Provider	**Inpatient Hospitalization**	**Partial Hospitalization**
Description	Inpatient hospitalization for major depression, anxiety or other mental health conditions	Intensive outpatient therapy up to 6 hours per day of individual, family & group therapies to support with mental health recovery
Benefit:	100% of Contracted Rate	100% of Contracted Rate
Deductible	None	None
Co-Insurance	None	None
Maximum Days per calendar year	30 days per calendar year	60 Days per calendar year
NON-MHN Provider	**Inpatient Hospitalization**	**Partial Hospitalization**
Deductible	$300 per day up to 5 days-Deductible	$300 per day up to 5 Days
Coinsurance	60/40% Cost Sharing	50/50% Cost Sharing
Maximum Out of Pocket Expense	$3,600 per Admission	NA
Maximum Days	30 Days per calendar year	60 Days per calendar year

INTENSIVE SUBSTANCE ABUSE BENEFITS

Precertification	Required for MHN & Non MHN Penalty-$500 per admission for non pre-certification-Must be obtained within 72 hours of admission.	
Maximum Benefit per calendar Year	$15,000 for the combined use of all the Substance Abuse Levels of Care, In or Out of Network.	
MHN Provider	**Inpatient and Outpatient Detox**	**Intensive Outpatient Program**
Description	Detoxification treatment for the abuse/use of legal and illegal substances which have impaired functioning	Intensive outpatient therapy up to 3 hours per day of individual, family & group therapies to support substance relapse
Co-Insurance	80/20% Cost Sharing of Contracted Rate 50% of the Contracted rate for re-admissions within 180 days from previous discharge	80/20% Cost Sharing of Contracted Rate
Deductible	None	None
Maximum Days per calendar year	Inpatient=20 Days Outpatient=30 Days	18 Days
NON-MHN	**Inpatient and Outpatient Detox**	**Intensive Outpatient Program**
Deductible per Episode	$300 per day up to 5 days	$500
Coinsurance	60/40% Cost Sharing -1st Admission 40/60% Cost Sharing for re-admissions within 180 Days from previous discharge	60/40% Cost Sharing
Maximum Days per calendar year	Inpatient=20 Days Outpatient=30 Days	18 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 MEDICAL MANAGEMENT AND CLAIMS REVIEW

Medical Management and Claim Review are provided by the Administrator for Behavioral Health, Substance Abuse.

8.00.05 FILING CLAIMS

Claims for the Treatment of Behavioral Disorders and Substance Abuse Program are filed with the TPA.

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

All Covered Behavioral Health Services must be pre-approved by the Behavioral Health Plan Administrator's Utilization Management in order to receive Plan Benefits at the highest level of reimbursement

8.01.01 NON-COMPLIANCE PENALTY

Failure to first contact the Behavioral Health Program Administrator will result in a 50% reduction of benefits.

8.02 COVERED SERVICES

The Plan pays for In-Patient treatment, Partial Hospitalization, and Outpatient treatment including Group Therapy.

8.03 BEHAVIORAL HEALTH EXCLUSIONS

The following are excluded from medical benefits and the Treatment of Mental Health/Substance Abuse services, unless otherwise indicated from Plan Manager.

1. Care and treatment of obesity, weight loss or dieting control whether or not it is, in any case, a part of the treatment plan for another sickness

2. Vitamins, minerals, or food supplements whether or not prescribed by an eligible provider.

3. Biofeedback;

4. Psychological testing other than depression screening;

5. Mental Health services for remedial education, including evaluation, testing or treatment of learning disabilities;

6. Mental health services required by court order and/or condition of parole or probation;

7. Environmental ecological treatment;

8. Mega-vitamin or orthomolecular therapy;

9. Hypnotherapy: and;

10. Sleep Disorders and sleep therapy; and

11. Axis II diagnosis unless there is an accompanying Axis I condition.

12. Electroshock Therapy

13. Services, treatment and supplies (such as Nicorette, patches, (NicoDerm Habitrol, etc.) related to smoking cessation outside of program guidelines.

14. Weekend Admissions except for medical emergencies.

15. Medical services needed due to self-inflicted Sickness or Injury, whether sane or insane. Follow-up care may be provided within the Treatment for Behavioral Health, if authorized by the Behavioral Health Plan Administrator.

16. 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;

17. Sexual dysfunction's or inadequacies, or other services related to gender reassignment or disturbance of gender identification.

18. 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.

SECTION 9 -PRESCRIPTION RETAIL OR MAIL ORDER

Effective July 1, 2005

Prescription Benefits

Prescription Plan Only Maximum Out-of-Pocket Expense *:
$1,400 per Individual
$2,800 per Family

Preferred Pharmacies include: Sweetbay Pharmacies, Pelots, Foster Drugs and Rx Solutions

Retail Pharmacy: 30 Day Supply maximum

Maximum co-pay is $100.00 per script for Retail and $300.00 per script for Mail Order

RETAIL PHARMACY	PREFERRED PHARMACY	NON-PREFERRED
Generic	No co-pay	$5.00 or 15% whichever is greater
Preferred Brand	$10.00 or 20% whichever is greater	$15.00 or 25% whichever is greater
Non-Preferred	$30.00 or 40% whichever is greater	$40.00 or 50% whichever is greater
Over-the-Counter (OTC) with a Prescription * **	No copay	$5.00

MAIL ORDER PHARMACY		
Generic	$12.00 or 15% whichever is greater	Not available
Preferred Brand	$38.00 or 25% whichever is greater	Not available
Non-Preferred	$75.00 or 40% whichever is greater	Not available

Specialty Pharmacy	Maximum $100 per Script	
Generic or Brand per Script	$25.00 or 20% whichever is greater	Not available

* 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.

*** Refer to www.ManateeYourChoice.com for an approved list.

9.00 PRESCRIPTION PROGRAM

The Manatee Choice Prescription Plan is a stand-alone program. Benefits are not included in the Medical Plan section of the Plan Document.

The Benefits, Deductibles, Co-payments, Exclusions and Limitations for the Prescription Drug Program are separate from the Comprehensive Medical Benefits outlined in other Sections of the Plan Document.

9.00.01 APPLICABLE TO ALL COVERED PERSONS

The Prescription Benefits, Deductibles, Co-pay, Coinsurance, Exclusions and Limitations are separate from the Comprehensive Medical Benefits outlined in other Sections of the Plan Document.

9.00.02 PRESCRIPTION PROGRAM MANAGEMENT (PPM)

The Prescription Benefit Manager (PBM) is contracted by the Plan Sponsor. The Plan Manager is responsible for the daily operation of the Prescription Plan.

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

The Prescription Drug Program 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 Prescription Drug Program participants if practicable.

9.00.03 PREFERRED DRUG LIST (PDL)

The Manatee Preferred Drug List includes a broad range of FDA approved brand name and generic prescription medications that are most commonly prescribed by our physicians. The PDL is developed by the PBM and is adjusted periodically on the recommendation of the PBM and approved by the Plan Manager.

PREFERRED DRUG LIST - ELIGIBLE RETAIL DRUGS

The Plan Manager may change the eligible drugs that may be dispensed according to the Preferred Drug List as recommended by the Prescription Benefit Manager and approved by the Plan's Medical Director.

9.00.04 PRIOR AUTHORIZATION

Prior Authorization may be required for some prescriptions and requires a written prescription, physician's contact and response through telephone or letter with the Plan's Prescription Benefit Manager (PBM). Prior Authorization is reviewed by the PBM's Clinical Pharmacist and approved according to clinical guidelines and evidence-based information provided by the prescribing physician. See Preferred Drug List for complete information on prior authorization. The toll-free number is on the back of the Member's ID Card. Following is a partial list of those drugs requiring prior authorization:

Interferon

Antidepressants

Cerebral stimulants

Topical Vitamin A Derivatives for the treatment of non-cosmetic conditions

Antimigraine Agents

Analgesics

Anti-inflammatory Medications

Antiulcer Agents

9.00.05 STEP THERAPY

Step Therapy Guidelines are based upon the recommendation of the PBM and approved by the Plan Manager; Step Therapy Guidelines are established for specific classes of prescriptions. Details are listed in the Preferred Drug List brochure. See Preferred Drug List for complete definition.

9.00.06 QUANTITY LIMITS

Based upon the recommendation of the PBM and approved by the Plan Manager, the Plan may establish quantity limits on specific drugs.

9.01 ELIGIBLE PRESCRIPTION DRUGS

The Plan pays for the following Eligible Drugs if prescribed by a Physician authorized to write Prescriptions according to the Laws of the State where the prescription is purchased.

Legend Drugs (those drugs requiring prescription except those excluded below)

Schedule V Drugs (including Cough Syrup with codeine)

Oral Contraceptives

Rx Strength Pre-Natal Vitamins

Insulin

Insulin Syringes

Diabetic Supplies (test Strip and Lancets)

Diabetic Medical Devices

9.02. LIMITED COVERAGE PRESCRIPTION DRUGS

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

Growth Hormones

Exceptionable Injectables

Neupogen

Epogen

Sandostatin

Under Special Conditions

Retin-A	Maximum to Age 29
Compounds	Maximum $200.00
Dexedrine	Maximum to Age 23

Adderall	Maximum to Age 23
Ritalin/Methylphenidate	Maximum to Age 23

9.03. PLAN EXCLUSIONS

The Following Drugs are not covered:

Drugs for weight reduction or control*

Drugs for infertility, including drugs for co-occurring conditions for the purpose of fertility if not otherwise indicated.

Injectables except insulin and specialty pharmacy drugs

Over the counter items except as approved by the Plan Administrator*

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

FDA non-approved drugs

Stimulants

Drugs for the treatment of erectile dysfunction

Smoking deterrents *

Drugs excluded by the Medical Plan

Experimental or Investigational Drugs

*Exceptions include those medications that are administered through a Your Choice comprehensive Program.

9.04. RETAIL PHARMACY EARLY REFILL EXCEPTION

At the Member's request, the Plan Manager 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.

10.00.01 FREEDOM OF CHOICE DENTIST PLAN

A Member selects the dentist of their choice to perform all services. Dentists listed in the Provider Directory agree to bill the Plan for the balance due but not more than the listed Reasonable and Customary amount as shown in the Schedule of Benefits.

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 participant pays 100% of the cost.

The amount to be deducted and the Payroll Deduction Forms are available from the Employee Health Benefits Office or your Insurance Coordinator.

10.00.03 RATES

The Schedule of Benefits for the Dental Plan contains the Premiums, Co-Payments, and Benefits for the Dental Plan.

10.00.04 ELIGIBILITY

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

10.00.05 WAITING PERIOD

New Employee:

A new employee will become eligible to join the Plan on the first day of the month following 60 days continuous employment.

Open Enrollment:

An employee who is not a member of the Plan under the rules of a "New Employee" will be offered the opportunity to join the Plan on the first day of January or such time the Plan Administrator declares "Open Enrollment". Thirty (30) days prior notice will be given to all employees on the "Open Enrollment" period.

10.00.06 REENTRY PLAN

An employee who cancels an individual, family or dependent membership must wait 24 months in order to rejoin the Plan. There will be a new Pre-existing Condition Period.

10.00.07 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 or any other Plan.

Dental expenses will be considered under the Dental Plan first. The balance of Dental expenses covered under the Plan Sponsor's Medical Plan will be considered secondary according to the Medical Plan schedule.

10.00.08 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.

10.00.09 PRE-TREATMENT REVIEW

If the charges for a course of treatment for Type III services (space maintainers, crowns, repairs to dentures and prosthodontics) will total more than $1,000 the Covered Person should submit a statement from the dentist 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. To allow for faster claims handling, the statement will be reviewed to determine what benefits, if any, are payable under this Plan.

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.

10.00.10 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 listed by code in the SCHEDULE OF BENEFITS which are subject to a Deductible, the amount payable will equal listed County Plan Payment (or the charge, if less) minus the Deductible. For those not listed, the amount payable will equal the Covered Percentage times the amount of Covered Charges in excess of the Deductible.

2. For procedures listed by code in the SCHEDULE OF BENEFITS which are not subject to a Deductible, the amount payable will equal listed County Plan Payment (or the charge, if less). For those not listed, the amount payable will equal the Covered Percentage times Reasonable and Customary amount of covered charges.

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

10.01.01 DEDUCTIBLES

Certain covered Dental Charges are subject to a Deductible. The Deductible is the amount of Covered Charges each Covered Person must incur before benefits are payable. The Deductible must be satisfied each Calendar Year.

Any charges incurred in the last three months of the Calendar Year which are used to satisfy the Deductible for that year will be applied towards the satisfaction of the Deductible for the next year. If two or more covered family members sustain injuries in the same accident while covered, only one Deductible must be met for charges incurred due to these injuries for the rest of the Calendar Year in which that accident occurred.

Once the Per Family Deductible has been reached, no other covered family member need satisfy the Deductible during that Calendar Year.

Deductible Per Calendar Year - Applies to procedures listed under Restorative Procedures, Prosthodontics-Removable, Crowns, Endodontics, Periodontics, Repairs to Dentures, Prosthodontics-Fixed, Oral Surgery and other services. (NOTE: Deductible does not apply to procedures marked with an asterisk).

Per Person…… $50.00

Per Family Maximum……. $150.00

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 MAXIMUM ALLOWABLE BENEFIT

The Maximum Allowable Benefit Payment is listed in the Schedule of Benefits - Fee Schedule under the heading "County Plan Payment" the amount the Plan Pays for a procedure according to the Procedure Code. (Request a copy of Fee Schedule from Employee Health Benefits)

10.01.05 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.

10.01.06 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.

10.01.07 CHANGE IN DEPENDENT STATUS

A Plan member must notify the Plan thirty (30) days in advance in writing prior to adding or canceling

coverage for a Dependent(s). The coverage for the Dependent will begin on the first day of the month following completion of the sixty (60) day Waiting Period.

10.01.08 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 below.

10.02.01 PREVENTIVE/DIAGNOSTIC PROCEDURES

10.02.02 ORAL EXAMS- (limited to 1 exam per Calendar Year).

10.02.03 PROPHYLAXIS- (limited to 2 times per Calendar Year).

10.02.04 TOPICAL APPLICATION of sodium fluoride or stannous fluoride (limited to 2 times per calendar year) (See Dental Schedule codes 1201-1205 for Coverage Limitations).

10.02.05 X-RAYS- (completed series or Panorex limited to 1 time in any 24 consecutive month period. Extra oral limited to 2 films per Calendar Year).

10.02.06 TESTS AND LABORATORY EXAMS related to dental procedures.

10.02.07 ORAL HYGIENE INSTRUCTION

10.02.08 SEALANTS (limited to children 13 and younger).

10.02.09 SPACE MAINTAINERS (limited to children 13 and younger). Includes all adjustments within 6 consecutive months of installation.

10.02.10 TYPE I PROCEDURES ……100% of Reasonable and Customary

Diagnostic	Test and laboratory Examinations
Radiographs	Preventive

10.02.11 TYPE II RESTORATIVE DENTAL PROCEDURES County Plan Payment Fee Schedule or 75% of the Reasonable and Customary Charges for dental procedures not listed in the County's Plan Fee Schedule as defined in Section 10.04 below.

a. fillings.

b. extractions.

c. oral surgery.

d. periodontal treatment and treatment of other diseases of the gums and tissues of the mouth.

e. endodontic treatment and related endodontic surgery, including root canal therapy.

f. repairs to prosthetics (full and partial dentures).

g. consultations for second opinions.

h. emergency treatment (palliative treatment for dental pain).

i. broken appointments.

10.02.12 **TYPE II PROCEDURE**…… County Plan Payment Fee Schedule or 75% of the Reasonable and Customary Charges for dental procedures not listed in the County's Plan Fee Schedule as defined in Section 10.04 below

Restorative	Endodontics
Periodontics	Oral Surgery
Other Services	

10.02.13 **TYPE III PROCEDURES**…….. County Plan Payment Fee Schedule or 50% of the Reasonable and Customary Charges for dental procedures not listed in the County's Plan Fee Schedule as defined in Section 10.04 below:

Space Maintainers	Crowns
Repairs to Dentures	Prosthodontics (Fixed and Removable)

10.02.14 **REPLACEMENT DENTAL PROCEDURES** ……. County Plan Payment Fee Schedule or 50% of the Reasonable and Customary Charges as defined in Section 10.04 below.

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 5 years 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.

10.02.15 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 90 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. implants; or

10. counseling on diet or nutrition; or

11. experimental procedures; or

12. completion of any forms; or

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

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

15. failure to keep an appointment; or

16. 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.

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

18. Orthodontic Treatment of any sort.

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

20. Crowns, bridges or dentures within the first 12 months of effective date.

10.04. SCHEDULE OF COVERED PROCEDURES Reasonable and Customary Charges and County Plan Payment.

Reasonable and Customary Charge(s) means charges made for medical services and supplies that are required for the care of the Covered Person that: (1) are normally charged by the provider for these services and supplies; (2) but not to exceed the amount normally charged within the same locale by most providers of similar services and supplies. Consideration will be given to: (1) the nature and severity of the condition for which the Covered Person needs care; and (2) any circumstances for which additional time, skill, or experience are required. In any case where a provider of services accepts as full payment an amount less than the Reasonable and Customary Charge that would have been accepted in the absence of coverage, that reduced amount will be the maximum Reasonable and Customary Charge.

10.04.01 County Plan Payment

County Plan Payment is a Schedule of Payment agreed to by participating Dentists to be paid by the Members and not to charge the Members the difference between the Reasonable and Customary Charges.

County Plan Payment is the amount the Plan Sponsor agrees to pay for a Procedure listed in the Schedule of Dental Benefits available from Employee Health Benefits.

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.

-If a Qualified Beneficiary 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 work hours being reduced, that Qualified Beneficiary may elect an additional 11 months of coverage under this Plan, subject to the following conditions:

-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.

-If the Qualified Beneficiary entitled to the additional 11 months of coverage has non disabled family members who are entitled to continuation coverage, those non disabled family members are also entitled to the additional 11 months of continuation coverage.

-36 months from the date the health coverage would have stopped due to the Qualifying Event other than those described above

-For the spouse or dependent of an Employee who was entitled to Medicare prior to a qualifying event that is either the termination of employment or work hours being reduced, 18 months from the date of the qualifying event or if later, 36 months from the date of the Employee's Medicare entitlement.

-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 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.

-The Qualified Beneficiary becomes legally separated from his or her spouse.

- 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.

Claims

File a claim by completing a medical claim form and attaching your bills to the form. "COBRA" should be written on the claim form and on each of the bills.

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.

-The Employee becomes entitled to benefits under Medicare.

-The Employee's death.

-The Employee's marriage is dissolved.

-The Employee becomes legally separated from his/her spouse.

-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 who 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 agree 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 have 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 a particular 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 he 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 benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.

-The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if the person is also a Medicare beneficiary and both of the following are true:

-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 written Proof of Claim satisfactory to the Plan Sponsor must be submitted to the Plan Sponsor within ninety (90) days after the date of the event for which the claim is made. Any Proof of Claim received more than ninety (90) days after the date of the event for which the claim is made will not be considered for payment Unless the claimant establishes to the satisfaction of the Plan Sponsor that: (1) it was impossible to submit the Proof of Claim in a timely manner, and (2) the Proof of Claim was submitted as soon as reasonably possible.

Notwithstanding the foregoing, in no event will the Plan Sponsor be required to consider a Proof of Claim submitted more than one (1) year following the end of the original ninety (90) day period, unless evidence acceptable to the Plan Sponsor is submitted establishing that the Covered Person was legally incapacitated throughout such period.

A Proof of Claim should be submitted on the forms provided by the Plan Sponsor. Proof of Claim forms will be provided to any claimant who submits to the Plan Sponsor a written notice identifying the Covered Person claiming a benefit as soon as reasonably possible following the date of the event for which a claim is made.

A Covered Person may submit a Proof of Claim in a different form than that provided by the Plan Sponsor, provided such form establishes to the satisfaction of the Plan Sponsor: (1) the occurrence of the loss, (2) the nature of the loss, and (3) the extent of the loss.

11.09 CLAIM PROCEDURES

The Plan Sponsor shall have the exclusive discretionary authority to determine whether the Proof of Claim should be paid or denied based on the terms of the Plan. If a claim for benefits is denied, either in whole or in part, the Plan Sponsor will notify the claimant in writing within ninety (90) days.

The ninety (90) day response period may be extended to one hundred and eighty (180) days from the date the Proof of Claim is submitted if special circumstances exist. A notice of denial of claims will refer to the reason or reasons for the denial of the claim; will have references to the Plan provisions upon which the denial is based; will describe any additional material or information necessary to perfect the claim and explain why such material information is necessary; and will have an explanation of the Plan's review procedure. If a written notice is not provided within ninety (90) days (or 180 days, if applicable), the claimant may treat the claim as if it has been denied.

11.10 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 Sponsor. During this time the claimant may review pertinent documents and submit in writing any document, issues and comments related to the claim.

11.11 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.

11.12 INCORRECT BILLING REWARD

The Plan Sponsor will investigate any notice from the Covered Person of Incorrect Billing or billing for services not actually rendered by a Physician, Hospital or Institution. The Plan Sponsor will notify the Covered Person if the Incorrect Billing is verified and payment of benefits will be reduced by the amount incorrectly billed. The Plan sponsor will pay the Covered Person 50% of the reduced amount up to $500.00.

11.13 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.

11.14 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.

11.15 RIGHT TO CLAIM REVIEW

If you receive denial of any part or all of a claim or are dissatisfied with the payment of a claim, you may request a review by notifying the Plan's Third Party Administrator within 60 days in writing Section 11.18.01. Your claim will be investigated and you should receive a response within 60 days from the date the Claims Administrator receives your request.

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. **AN AMBULATORY SURGICAL CENTER** which is part of a Hospital, as defined herein, shall be considered an Ambulatory Surgical Center for the purposes of this Plan.

5. **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.

6. **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.

7. **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.

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

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

10. **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.

11. **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.

12. **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.

13. **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.

14. **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.

15. **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 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.

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

17. **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.

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

19. **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.

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

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

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

23. **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.

24. **FULL-TIME EMPLOYEE** means an Employee who is on the Employer's regular payroll and is scheduled to work for at least 30 hours each week. Full-time Employee will not mean a part-time or temporary Employee.

25. **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.

26. **HEALTH CARE PROVIDERS** means 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. **LATE ENROLLEE** means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

37. **MANATEE HEALTH NETWORK** is a Preferred Provider Network operating in Manatee and nearby counties. Access to the Manatee Health Preferred Provider Network is only available to persons enrolled in the Plan Sponsored Medical and Dental Plans, or other employers approved by the Board of County Commissioners.

38. **MANATEE HEALTH NETWORK HOSPITAL** means an Institution which meets the definition of a Hospital in this Plan that has an enforce contract with Third Party Administrator, at the time the services are rendered, to provide hospital services to Covered Persons.

39. **MANATEE HEALTH NETWORK INSTITUTION** means an Institution, such as a laboratory or Outpatient Surgery Facility that has an in force Manatee Health Network contract with Third Party Administrator, at the time services are rendered, to provide medical services to Covered Persons.

40. **MANATEE HEALTH NETWORK PHYSICIAN** means a physician who meets the definition of physician in this Plan who has an enforce Manatee Health Network contract with Third Party Administrator, at the time the services are rendered, to provide health care services to Covered Persons.

41. **MANATEE HEALTH NETWORK PROVIDER** means any 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 Third Party Administrator for designation as a Manatee Health Network Provider. Such provider may apply for and receive such designation as a Manatee Health Network Provider by Third Party Administrator.

42. **MANATEE HEALTH NETWORK SERVICE AREA** means any county that there is a Manatee Health Network panel of providers established.

43. **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.

44. **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.

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

46. **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.

47. **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.

48. **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.

49. **PART-TIME OR TEMPORARY EMPLOYEE** means an Employee who works less than 30 hours per week or is hired as a temporary employee for not less than 3 months or more than 6 months.

50. **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.)

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

52. **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. .

53. **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.

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

55. **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 period starts with the first day of employment.

56. **56./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.

57. **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.

58. **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.

59. **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.

60. **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.

61. **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.

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

63. **TOTAL DISABILITY OR TOTALLY DISABLED** means that due to Sickness or Injury a Covered Person is: (1) under a Physician's care; and (2) not able to do substantially all the normal activities of a person of like age and sex who is in good health; and (3) not engaged in any occupation or business for income or profit, for which You are reasonably qualified by education, training or experience. (This applies only if You were actively employed immediately before You become Totally Disabled.)

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

65. **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: R. B. SHORE

By:_____

Clerk of the Circuit Court