Halifax Health

Employee Medical & Dental Benefits Handbook

Effective January 1, 2016
ADOPTION OF THE PLAN DOCUMENT

Adoption
Plan Sponsor hereby adopts this Plan Document as the written description of its Employee welfare benefit Plan (the "Plan"). This Plan Document replaces any prior statement of the health care coverages of The Plan and is effective on the date shown below.

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

- Medical Coverage (if elected)
- Prescription Drug Coverage (if medical coverage elected)
- Dental Coverage (if elected)

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

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

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

Acceptance of the Plan Document
IN WITNESS WHEREOF, The Plan Sponsor has caused this instrument (pages 1-57 inclusive) to be executed, effective as of January 1, 2016.

Plan Sponsor/Plan Administrator: HALIFAX HEALTH/HALIFAX HEALTH PLAN

Date: _________________ By: _____________________

Signature

____________________________________
Print Name & Title of Signatory
# TABLE OF CONTENTS

Table of Contents ........................................................................................................................................... i

Introduction ...................................................................................................................................................... ii

Cost Containment and You ................................................................................................................................. iii

Choice of Providers ........................................................................................................................................... iii

General Information ........................................................................................................................................ iv

Your Eligibility & Effective Dates .................................................................................................................... 1-4

Extension of Coverage Provisions .................................................................................................................... 4-5

General Medical Provisions .............................................................................................................................. 6-7

Pre-certification and Utilization Review Program ........................................................................................... 8-10

Covered Medical Expenses ............................................................................................................................... 11-20

Medical Benefit Exclusions & Limitations ........................................................................................................ 21-26

General Claim Provisions ............................................................................................................................... 27

Filing a Claim for Medical Benefits .................................................................................................................. 28

Claim Denial and How to Appeal A Denial of Benefits ..................................................................................... 28

Coordination of Benefits .................................................................................................................................. 29-30

Subrogation, Reimbursement & Third Party Recovery Provision ..................................................................... 31-32

General Plan Provisions .................................................................................................................................. 33-35

COBRA Continuation of Coverage .................................................................................................................. 36-40

Dental Plan .......................................................................................................................................................... 41-42

Definitions ......................................................................................................................................................... 43-55

Covered Preventive Health Services .................................................................................................................. 56-59

Miscellaneous Forms and Policies ................................................................................................................... a-r
HALIFAX HEALTH
EMPLOYEE HEALTH & DENTAL BENEFIT PLAN

INTRODUCTION

Halifax Health, the “Plan Administrator,” has retained the services of Volusia Health Ventures (hereinafter referred to as VOLUSIA HEALTH NETWORK), experienced in claims processing, to handle health and dental claims.

This Plan is maintained for the exclusive benefit of the employees and each employee’s rights under this Plan are legally enforceable. The Employer has the right to amend this Plan at any time, and will make a “good faith” effort to communicate to you, on a timely basis, all such changes which affect benefit payment.

If you receive any information on this Plan and it is contradictory or silent in describing this Plan, this Employee Medical & Dental Benefits Handbook will prevail and is the governing document for this Plan.

The requirements for being covered under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including any limitations and exclusions), and the procedures to be followed in presenting claims for benefits and remedies available for appeal of claims denied are outlined on the following pages of this booklet.

You are entitled to this coverage if you are eligible in accordance with the provisions in this booklet. This booklet is void if you have ceased to be entitled to coverage. No clerical error will invalidate your coverage if otherwise validly in force. No clerical error will validate coverage that does not otherwise exist in this Plan.

Some of the terms used in the booklet begin with a capital letter. These terms have a special meaning under this Plan and they are listed in the Definitions section. When reading the provisions of this Plan, it may be helpful to refer to this section. Becoming familiar with the terms defined there will give you a better understanding of the procedures and benefits described.

Any questions you may have about your coverage should be directed to:

VOLUSIA HEALTH NETWORK
Post Office Box 2814
Daytona Beach, FL 32120-2814
386.425.4846
COST CONTAINMENT AND YOU

The cost of the nation's medical care delivery system continues to be inflationary and it has become imperative that efforts be made for the containment of these costs.

The responsibility for cost containment must be shared by all of us. Active participation in physical fitness can be a factor in avoiding some illnesses and in minimizing the seriousness of others. Should medical attention become necessary however, there are procedures that can be taken, and in some instances required, to avoid unnecessary expenses. Pre-admission certification is one of the cost containment measures outlined in this booklet.

CHOICE OF PROVIDERS

The Plan Administrator has entered into a contractual agreement with Exclusive Provider Organizations (EPO) so that certain providers of health care may offer their services. For directories, questions or information regarding the Exclusive Provider Organization or a Network Provider, please refer to our web site, www.myvhn.com, or call our Provider Relations Department at 386.425.4846, option 3.

Covered Persons, who reside within an EPO service area, have a choice of obtaining health care services and supplies from providers participating in the Exclusive Provider Organization (EPO providers). Non-EPO Providers are not covered and the member is responsible for all charges incurred.

EPO providers have agreed to provide services to Covered Persons at a negotiated discounted rate. Therefore, to encourage the use of EPO providers whenever possible, the Plan will generally provide a better benefit for their services.
## GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Name of the Plan:</th>
<th>HALIFAX HEALTH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Administration:</td>
<td>The Plan is a self-funded health plan and the administration is provided through a third party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees.</td>
</tr>
</tbody>
</table>
| Address of Plan:           | 303 Clyde Morris Boulevard  
                             | Daytona Beach, Florida 32114 |
| Group No.:                 | 1                   |
| IRS Employer Identification Number: | 59-6001217 |
| Plan Effective Date:       | January 1, 2016     |
| Plan Year:                 | January 1 – December 31 |
| Plan Supervisor:           | VOLUSIA HEALTH NETWORK  
                             | Post Office Box 2814       
                             | Daytona Beach, FL 32120-2814 |
| Plan Sponsor:              | Halifax Health      |
| Plan Administrator:        | Halifax Health      |
| Agent for Service of Legal Process: | Halifax Health |
| Contributions:             | Medical benefits are contributory for both Employees and their eligible Covered Dependents. Benefits are self-funded from the contributions from both the Employer and the Employees. |
| Employee Definition:       | Full-Time Employees and Specified Part-Time Employees. |
| Effective Date of Coverage:| First of month following waiting period |
| Waiting Period:            | First of the month following 30 calendar days after the date of hire. |
| Termination Date of Coverage: | On last day in which the covered participant ceases to be in one of the eligible classes. |
YOUR ELIGIBILITY AND EFFECTIVE DATES

EMPLOYEE ELIGIBILITY

Eligibility. If you are a Full-Time Regular Employee, or a Specified Part-Time Employee, you and your Dependents will be eligible to participate in the Plan after the Eligibility Waiting Period described below. Part-time employee status is defined as 20 – 31 hours worked per week and being in a benefit-eligible status, not casual pool.

Eligibility Waiting Period. Coverage becomes effective on the first day of the month following 30 calendar days of continuous service. The waiting period may be waived for members of acquired groups.

If an Employee is full-time with benefits, then becomes part-time, and then returns to full-time, they will not have a waiting period for benefits.

If an Employee is hired as part-time and later becomes full-time, the applicable waiting period of eligibility will be waived as long as they have acquired 30 calendar days of service.

Enrollment Requirement. You must be a Full-Time Employee or a Specified Part-Time Employee and meet eligibility requirements to enroll. You have 30 days from your eligibility date to deliver a completed Enrollment form to the Plan Administrator.

Effective Date of Employee Coverage. First of the month following 30 calendar days after the date of hire.

EMPLOYEE COVERAGE

Late Applicants – Employees & Dependents. If you do not enroll for the Coverage for which you are eligible (Employee and Dependent) within 30 days of your eligibility date, you will not be entitled to apply for Coverage in the Plan until the next Annual Enrollment Period unless there is a Change in Status or a Special Enrollment Period.

Change in Status. If, as a result of a "Change in Status," you have the right to add additional coverage, then you will have 30 days after the date of the event that constituted the "Change in Status" to notify the Plan of your new election. Coverage will be effective on the first day of the month after the date application for coverage is made. If you fail to notify the Plan within this 30-day period, you would not be eligible to apply for the additional coverage until the next "Open or Annual Enrollment" which will be announced each year. Coverage will be effective on the first day of the next month after the date application for coverage is made.

If, as a result of a "Change in Status," you have the right to reduce coverage, then you will have 30 days after the date of the "Change in Status" to notify the Plan of your election to reduce coverage. If you notify the Plan within this 30-day period, the reduced coverage will apply retroactively to the date acceptable proof of the "Change in Status" is supplied to the Plan Administrator. If, however, you notify the Plan after this 30-day period, you will not be entitled to a refund of any premiums you may have paid after the date of the "Change in Status" even though, under the group health care Plan coverage may have ceased for a Dependent on the date of the "Change in Status."
YOUR ELIGIBILITY AND EFFECTIVE DATES (Continued)

Special Enrollment. If you do not enroll in the Plan within the 30 days of eligibility, you may not enroll in the Plan until the next "Open or Annual Enrollment" However, if you decline enrollment in the Plan for yourself or your Dependents (including your legally married spouse) because of other health insurance coverage, you may in the future be eligible for "Special Enrollment" which would allow you to enroll yourself or your Dependents in the Plan, but only if both of the following occur:

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

2. You request enrollment within 30 days after the other coverage ends.

If you meet these requirements, your coverage will be effective on the first day of the month following receipt of the fully completed enrollment form.

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

In addition, if you have a new Dependent or Dependents as a result of marriage and you are otherwise eligible for coverage under the Plan, you may enroll yourself and your new Dependent(s) provided that you request enrollment within 30 days after the marriage. If timely application is made, coverage will be effective on the first day of the month following receipt of the fully completed enrollment form.

If you have a new Dependent as a result of birth, adoption, or placement for adoption and you are otherwise eligible to be enrolled in the Plan, you may enroll yourself and your legally married spouse provided that you request enrollment within 30 days after the birth, adoption or placement for adoption. If timely enrollment is made, coverage will be effective as of the date of the birth, adoption or placement for adoption.

Retiree. A retiree in the Halifax Health Plan is defined as someone who has been employed at Halifax Health for 10 or more years and has attained either the age of 62, or 30 years of employment. Eligible covered dependents of retired employees may elect to continue coverage (via COBRA continuation) in the event that the retired employee either terminates coverage due to enrollment in Medicare, or dies.
YOUR ELIGIBILITY AND EFFECTIVE DATES (Continued)

DEPENDENT ELIGIBILITY

If both spouses are eligible for Coverage under The Plan, only one may enroll for Dependent Coverage. Also, an Employee cannot be covered as both an Employee and as a Dependent under this Plan.

**Dependent Eligibility Requirements.** Dependents cannot enroll unless you, the Employee, are covered under The Plan. Each Dependent is eligible to enroll only if that person satisfies the definition of Dependent. Each new Dependent must be enrolled within 30 days from the date:

1. You marry, for spouse and stepchildren:
2. A child is born to you (see Newborn Eligibility Requirements);
3. A child is placed in your home for purpose of adoption ("placed" means the date when you have accepted legal responsibility for that child); or
4. You are legally responsible for a foster child.

**Newborn Eligibility Requirements.** Please enroll your newborn as soon as possible. Your newborn child is not automatically covered at birth. To obtain coverage for your newborn, you must notify your Employer of the birth and pay any required contributions within 30 days from the date of the newborn’s birth. If notification and contributions are not made, you will not have coverage for your newborn. **Note:** Your claim for maternity expenses is not considered as notification to your Employer for Coverage to be added for your newborn. Coverage is effective on the newborn’s birth date if proper notification is made.

**Effective Date of Dependent Coverage.** If the Enrollment Form is received by VOLUSIA HEALTH NETWORK within 30 days from the date the Dependent can enroll, Coverage is effective on the Dependent’s eligibility date.

**STATEMENT OF NON-DISCRIMINATION IN ELIGIBILITY REQUIREMENTS**

No individual, Employee or Dependent, otherwise eligible for coverage under The Plan, shall be denied enrollment into the Plan on the basis of a Health Factor.
YOUR ELIGIBILITY AND EFFECTIVE DATES (Continued)

TERMINATION OF COVERAGE

Plan Termination. The Plan (or any of its benefits) terminates on the date your Employer: (1) terminates any or all benefits under The Plan, (2) discontinues or suspends active business operation, (3) is placed in bankruptcy (except Chapter 11) or receivership, (4) loses its business by dissolution, merger or otherwise, unless other arrangements are made.

The Plan would also terminate at the end of the period for which required premium payments are not received.

Employee Termination. Employee termination occurs the day which the Employee, (1) is no longer in an eligible class of Employees, (2) is no longer making contributions, (3) requests termination of Coverage, (4) enters full-time military service, (5) retires (unless there is Retiree Coverage) or (6) terminates employment.

Dependent Termination. Termination of Coverage for you, the Dependent, occurs on the same day of the month in which Employee Coverage terminates, you enter full-time military service, or you no longer satisfy the definition of "Dependent," as described in this booklet.

EXTENSION OF COVERAGE PROVISIONS

After the termination of Coverage date (as determined by the Termination of Coverage section), Coverage may be continued in the circumstances identified below. Unless expressly stated otherwise, however, Coverage for a Dependent will not extend beyond the date the Employee's Coverage ceases.

EXTENSION OF COVERAGE FOR HANDICAPPED DEPENDENT CHILDREN. If a Covered Dependent child attains the age which would otherwise terminate his or her status as a "Dependent" and:

1. if on the day immediately prior to the attainment of such age the child was a Covered Dependent under The Plan; and

2. at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation or physical handicap or disability which commenced prior to the attainment of such age; and

3. such child is primarily Dependent upon a parent for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of his or her having attained the specified age and he or she will continue to be considered a Covered Dependent under The Plan so long as he or she remains in such condition, and otherwise conforms to the definition of "Dependent."

The Employee must submit to the Contract Administrator proof of the child's incapacity within thirty (30) days of the child's attainment of such age, and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.
EXTENSION OF COVERAGE PROVISIONS (Continued)

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA). Regardless of the Employer's established Leave of Absence policy, This Plan will at all times comply with the regulations of the Family and Medical Leave Act of 1993 as set forth by the Department of Labor.

If an Employee does not return to work from FMLA leave, Coverage under This Plan will terminate unless election is made to continue Coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The Qualifying Event for COBRA is the date the Employee's employment is formally terminated and not the date the Employee first took FMLA leave.

It is The Plan's intent to comply with all requirements of the Family Medical Leave Act. If any Plan provision is incomplete or in conflict with the requirements of the law or its Amendments, the law will prevail.

EXTENSION OF COVERAGE DURING MILITARY SERVICE. Regardless of an Employer's established Leave of Absence policy, The Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee or Dependent entering or returning from military service. These rights include up to 24 months of extended health care Coverage upon payment of the entire cost of Coverage plus a reasonable administration fee and immediate Coverage in This Plan upon return from service.

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

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

RESUMING COVERAGE UNDER THE PLAN AFTER BEING COVERED BY COBRA. Coverage under The Plan will resume for any individual who returns to work with the Company who had elected COBRA Continuation Coverage. Coverage for the Employee and Covered Dependents will be the same as the Coverage that was in effect under COBRA Continuation Coverage.

The “Effective Date of Employee Coverage” section (under YOUR ELIGIBILITY AND EFFECTIVE DATE) does apply to individuals returning to work after electing COBRA coverage.

Individuals will be credited with the amount of time they were covered under The Plan prior to and including any time covered under COBRA or similar provisions under The Plan.
GENERAL MEDICAL PROVISIONS

All benefits provided under This Plan must satisfy some basic conditions. The following terms and conditions are commonly included in health benefit Plans but are often overlooked or misunderstood.

MEDICAL NECESSITY. The Plan provides benefits only for Covered Services and supplies that are Medically Necessary for the treatment of a covered Illness or Injury. The treatment must also be generally accepted by medical professionals in the United States and be non-Experimental or educational in nature. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion.

LIFETIME. The word Lifetime, as used in this document, means the total period of time a Covered Person participates in This Plan, including any one or more interrupted periods of Coverage in the Covered Person's Lifetime.

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

CALENDAR YEAR DEDUCTIBLE. Once each Calendar Year each separate Covered Person must satisfy the Individual Calendar Year Deductible amount shown in the Employee Medical & Dental Benefits Handbook. Benefits are based on the person's Covered Expenses that exceed the Deductible amount.

FAMILY DEDUCTIBLE. The Family Deductible can be satisfied by combining the amounts paid toward covered expenses for all covered family members. The Family Calendar Year Deductible amount is shown in the “Summary of Benefits and Coverage”.

When the Family Deductible is satisfied, no further Deductible will be applied for any covered family member during the remainder of that year.

PLAN PERCENTAGES. The Plan Percentage is the portion The Plan will pay for eligible Covered Expenses, after you satisfy any applicable Deductible(s) or Co-payment(s). Your choice of Provider will determine the amount of the Plan Percentage. The Plan Percentages for Covered Expenses are shown on the “Summary of Benefits and Coverage”.

TRACKING OUT-OF-POCKET EXPENSES. Not all charges or amounts paid toward Covered Expenses track toward satisfying your Out-of-Pocket expenses, and the Plan Percentage for certain benefits may not be increased even though the Out-of-Pocket Maximum amount has been met.

The following items do not track to the Out-of-Pocket Maximum amount:

1. Any penalties imposed for failure to comply with any Pre-certification requirements.
2. Expenses above the Benefit Maximums stated in the “Summary of Benefits and Coverage”.
3. Any ineligible or excluded charges under this Plan.
MAXIMUM OUT-OF-POCKET EXPENSE. The Plan is responsible for paying for any Covered Expenses at the Plan Percentage(s) shown in the “Summary of Benefits and Coverage”. The remaining portion of the charge is your Out-of-Pocket expense.

The Maximum Out-of-Pocket Expense is the total amount that must be paid toward Covered Expenses during a Calendar Year before the Plan Percentage of The Plan automatically increases. However, the Plan Percentage for certain benefits does not increase even though the Out-of-Pocket Maximum amount has been met. Refer to "TRACKING OUT-OF-POCKET EXPENSES" above.

INDIVIDUAL MAXIMUM OUT-OF-POCKET EXPENSE. When a covered individual has paid the Maximum Out-of-Pocket in a Calendar Year for covered medical expenses, this Plan's Percentage will automatically increase to 100%.

FAMILY MAXIMUM OUT-OF-POCKET EXPENSE. When a covered family has paid the Maximum Out-of-Pocket in a Calendar Year for covered medical expenses, this Plan's Percentage will automatically increase to 100%.

MAXIMUM BENEFITS. Total Plan payments for each Covered Person are limited to certain Benefit Maximums shown in the Summary of Medical Benefits. A Benefit Maximum can apply to a specific benefit. A Benefit Maximum can be a specific limit on services, such as number of visits or days; a specific time period, such as Calendar Year; or any other specific limit imposed upon a benefit, or benefits, by The Plan.
## PRE-CERTIFICATION AND UTILIZATION REVIEW PROGRAM

### VHN PRE-CERTIFICATION LIST
- Pre-cert required for all inpatient confinements including skilled nursing, residential treatment, inpatient rehabilitation and all outpatient surgical procedures performed in Ambulatory Surgical Centers or hospitals.

### Additional Procedures—PRE-CERT REQUIRED

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy—RAST</td>
<td>Hyperbaric oxygen therapy</td>
</tr>
<tr>
<td>Blood test—BRAC analysis, colaris</td>
<td>Interventional Pain Management (except trigger point inj)</td>
</tr>
<tr>
<td>Cardiac Catheterization/nuclear cardiac stress test</td>
<td>Laser Therapy (excludes yag laser after cataract)</td>
</tr>
<tr>
<td>Cardiac CT - Angiogram</td>
<td>Lithotripsy</td>
</tr>
<tr>
<td>Childbirth over 48 hr-Vaginal delivery</td>
<td>MOHS (if not performed on face or ear)</td>
</tr>
<tr>
<td>Childbirth over 96 hr-C-Section delivery</td>
<td>Myelogram</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Nuclear Cardiac Stress test</td>
</tr>
<tr>
<td>Durable Medical Equipment &gt; $300 per item</td>
<td>Panendoscopy</td>
</tr>
<tr>
<td>Endoscopic Ultrasound</td>
<td>PET Scan—Cardiac only; CT Angiogram cardiac</td>
</tr>
<tr>
<td>EGD (Upper Endoscopy)</td>
<td>Phototherapy except for skin or bilirubin</td>
</tr>
<tr>
<td>ENT Turbinate Resection (in office)</td>
<td>Sleep apnea treatment</td>
</tr>
<tr>
<td>Genetic Testing (including prenatal)</td>
<td>Varicose vein treatment</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Weight Management</td>
</tr>
<tr>
<td>Home infusion (&gt;$300 per dose)</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Procedures—PRE-CERT NOT REQUIRED

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Skin testing</td>
<td>Hemorrhoidectomy and/or Sigmoidoscopy</td>
</tr>
<tr>
<td>Amniocentesis</td>
<td>Hernia Repair</td>
</tr>
<tr>
<td>Battery changes for cardiac defibrillator</td>
<td>Hospice</td>
</tr>
<tr>
<td>Biopsies—all biopsies (includes fine needle aspirations)</td>
<td>Lupron Injections</td>
</tr>
<tr>
<td>Bone density (DEXA)-time specific-check benefits</td>
<td>MRI</td>
</tr>
<tr>
<td>Breast procedures related to cancer including mastectomy and post-mastectomy reconstruction</td>
<td>Oncotype blood test</td>
</tr>
<tr>
<td>Bronchoscopy</td>
<td>Partial hospitalization for alcohol/chemical dependency</td>
</tr>
<tr>
<td>Cardiac Rehab (after event such as MI, stent placement, CABG)</td>
<td>PET Scan-except cardiac PET</td>
</tr>
<tr>
<td>Cardiac Treadmill Exercise Test</td>
<td>Sleep Apnea/diagnosis</td>
</tr>
<tr>
<td>Cataract Extraction/yag laser after cataract</td>
<td>TMJ/CMJ</td>
</tr>
<tr>
<td>Cervical Cerclage</td>
<td>Transport-Emergency</td>
</tr>
<tr>
<td>CT Scans</td>
<td>Transport-non emergency (facility to facility only)</td>
</tr>
<tr>
<td>Cystoscopy with or without stent insertion or removal</td>
<td>Trigger point injections</td>
</tr>
<tr>
<td>DME-all rental</td>
<td>Tubal Ligation/vasectomy</td>
</tr>
<tr>
<td>ERCP with insertion of stent or stent removal</td>
<td>Ultrasound (including Level 2 OB u/s)</td>
</tr>
<tr>
<td>Hardware removal-orthopedic or oral/facial</td>
<td>Vasectomy</td>
</tr>
</tbody>
</table>

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Failure to comply will result in a non-pre-certification penalty.

Non-Pre-certification Penalty (Local Network) ............ 50% per occurrence
Non-Pre-certification Penalty (Extended Network) ....... 100% per occurrence
Pre-certification and Utilization Review will be performed by VOLUSIA HEALTH NETWORK. VOLUSIA HEALTH NETWORK may be contacted 24 hours a day, 7 days a week at 386.425.4846, option 5 (voice message should be left after regular business hours).

The member is ultimately responsible for making sure the pre-certification process is complete, however, the member’s physician’s office must notify the Utilization Management Department at least 10 days prior to the scheduled Inpatient admission or prior to the start of other care requiring Pre-certification by either telephone or fax.

Please be advised that no retrospective reviews will be performed if requested more than 14 days after the date of service.

If the admission is for a Medical Emergency, you or someone on your behalf should contact the Utilization Management Department immediately or within 24 hours following the Emergency admission. See the Definitions section for what constitutes a Medical Emergency.

Pre-certification and Utilization Review will be performed by VOLUSIA HEALTH NETWORK. VOLUSIA HEALTH NETWORK is available 8:00am to 4:00pm Eastern Time Monday through Friday at 800.741.2198 or locally at 386.425.4846. Any calls that are received outside these times are connected to an “After Hours Voicemail.” These voicemails are retrieved first thing the following business day. The fax number is 386.425.7507.

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

PRE-ADMISSION REVIEW. Pre-admission Review determines if a Hospital Admission, surgical procedure, or other care requiring Pre-certification is medically necessary. All members should review the required pre-certification list to avoid reduction in benefits.

Please keep in mind that Pre-certification does not mean that all charges incurred will be covered nor does it guarantee payment of any benefits. All other terms, limits, and exclusions of The Plan still apply.

You, your Dependent, or the Physician concerned may request reconsideration of any Review decision. Any such request must be made within 60 days after the initial decision.

CONTINUED STAY REVIEW. Continued stay review is a process that assures the length of stay in the Hospital is Medically Necessary for your medical condition whether you are admitted for non-Emergency or Emergency treatment.

DISCHARGE PLANNING. When Hospitalization is no longer necessary, the hospital case managers work with Volusia Health Network’s utilization coordinators to provide for your continued needs by assisting in arranging for home care services, skilled nursing care, or medical equipment that you will require. This process helps assure that every patient is provided with appropriate care after an Inpatient Hospital Stay.
PRE-CERTIFICATION AND UTILIZATION REVIEW PROGRAM  
(Continued)

MEDICAL CASE MANAGEMENT. The primary objective of Medical Case Management is to identify and coordinate cost effective medical care alternatives to help manage the care of patients who have catastrophic or extended care Illnesses or Injuries by incorporating large case management. Potential large case management cases are identified by diagnosis and procedures captured in the pre-certification process.

The Utilization Management coordinators, in conjunction with large case management, also coordinate services for the management of large or potentially large claims.

The Plan Sponsor reserves the right to monitor health care and modify Plan benefits to assure that high-quality medical care is provided in the most cost-effective settings.

SPECIAL NOTICES

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

Also, prior authorization is not a guarantee of Coverage. The Utilization Review Program is designed ONLY to determine whether or not a proposed course of treatment is medically necessary. Benefits under The Plan will depend upon the person's eligibility for Coverage and The Plan's limitations and exclusions.
COVERED MEDICAL EXPENSES

Unless otherwise specified, payment for the covered medical expenses listed below will be made at the Plan Percentages shown in the separate documents, “Summary of Benefits and Coverage”, available for the Premier Exclusive Provider Organization (EPO Plan), subject to any Deductible amounts, any limitations, the definitions, and all other provisions of This Plan. The Plan will not pay any benefit expenses that exceed the Usual, Reasonable and Customary charge amount.

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

ALCOHOL AND DRUG DEPENDENCY. Benefits will be paid as shown in the “Summary of Benefits and Coverage”.

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

Treatment of Alcoholism or Drug Abuse must be given under the direction of a Physician and the treatment program must be accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) or by equal standards. This includes JCAHO or state approved Alcoholism rehabilitation programs or licensed Drug Abuse rehabilitation programs.

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

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

- Day Treatment
  The Plan will pay for charges incurred if treatment involves Day Treatment or a combination of Inpatient and Day Treatment.

AMBULANCE CHARGES. Benefits are payable for emergency or medically necessary transportation to the nearest Hospital or other care facility by a professional ground or air ambulance service, to transport a covered individual to the nearest facility appropriate for the Covered Person's condition.

ANESTHESIA CHARGES. Benefits are payable for the charges for anesthetics and the administration of anesthesia by a licensed Anesthesiologist or certified Registered Nurse anesthetist in connection with a covered Surgical Procedure when these are not covered as Hospital charges.

BARIATRIC SURGERY CHARGES. Benefits are payable for the charges associated with Bariatric Surgery upon approval and completion of the Halifax Health Weight Management Program and procedure performed by specific contracted providers.

BLOOD. Benefits are payable for charges for blood and/or blood plasma (if not replaced by or for the patient), including blood processing, equipment, and administration services.
COVERED MEDICAL EXPENSES (Continued)

BIRTHING CENTERS. Benefits are payable for the charges made by a licensed in-network Birthing Center (as defined in the “Definitions” section) for a Covered childbirth, and the associated normal services and supplies. No Room and Board Charges must be incurred, and recuperation must take place at home.

BREASTFEEDING SUPPLIES AND SUPPORT. Benefits are payable for lactation support and counseling (up to 8 visits per delivery) and one manual Medela breast pump within 6 weeks of delivery. Benefits are payable for a double pump accessory kit that connects to an electric pump, if the member chooses to purchase an electric Medela breast pump. Electric pumps are not covered by the Plan.

CARDIAC REHABILITATION THERAPY. Expenses incurred are covered for cardiac rehabilitation therapy subject to the following:

- The covered person must be recovering from a myocardial infarction (heart attack), cardiovascular surgery or a diagnosis of angina pectoris but only when the diagnosis is established prior to the start date of the rehabilitation program as evidenced by a record of prior treatment.
- Cardiac rehabilitation therapy must be prescribed by a licensed medical physician who is receiving regular progress reports concerning the covered person’s progress.
- Cardiac rehabilitation therapy must be conducted at a medical facility. Proper monitoring equipment and qualified medical personnel must be present during therapy in order to effectively respond to any emergency situation.
- In order for charges for therapy which extend beyond 12 weeks to be considered as covered expenses following a myocardial infarction or coronary surgery, medical documentation is required to establish:
  - The patient is not on a maintenance exercise program
  - Continuation of the monitored exercise program is necessary to enable the patient to reach an acceptable level of individual exercise tolerance consistent with the particular state of this person’s disease.
- Charges for cardiac rehabilitation therapy for angina pectoris extending beyond 12 weeks will be denied on the basis a monitored exercise program is no longer considered Medically Necessary for the treatment of the disease involved.

The Plan specifically excludes dietary instruction, educational services, behavior modification, literature and membership in health clubs, exercise equipment, preventive programs and any other items specifically excluded under the “Medical Benefit Exclusions and Limitations” section of the Plan.
COVERED MEDICAL EXPENSES (Continued)

CHIROPRACTIC SERVICES/SPINAL MANIPULATION. Benefits will be paid as shown in the “Summary of Benefits and Coverage”, subject to the benefit maximum(s) shown, for Medically Necessary Chiropractic treatment. Benefits will include the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebra) column. Benefits also include the application of treatment modalities such as, but not limited to diathermy, ultrasound, and heat and cold to the skeletal system to restore proper articulation of joints, alignment of bones or nerve functions.

COSMETIC, RECONSTRUCTIVE OR CORRECTIVE SURGERY. Benefits are payable for expenses incurred for reconstructive Surgery, only if such Surgery is necessary to correct a deformity or to restore or provide normal bodily function lost as a result of an injury or illness; or for reconstructive Surgery due to a congenital disease or anomaly which has resulted in a functional defect of a covered dependent child. Elective cosmetic surgeries are not covered.

DIAGNOSTIC SERVICES. The Plan will pay for diagnostic x-rays, electrocardiograms; electroencephalograms; ultrasound; amniocentesis; or other laboratory and pathology tests prescribed by a doctor and performed as the result of a covered Accident or Illness. Also covered is genetic testing if there is a family history of genetic disorders, and allergy testing, by any method, based on the type and number of tests performed by the same Physician. The services of a professional radiologist or pathologist are also covered.

DIALYSIS SERVICES. Dialysis services, including training, when provided and billed for by a Hospital, freestanding dialysis center or other appropriate Covered Provider.

DIABETIC FOOTWEAR. The Plan will pay for one pair of therapeutic shoes (diabetic shoes) and inserts (up to three pairs) per year for people with diabetes. Shoes and inserts must be prescribed by a contracted network provider; however, the treating M.D. or D.O. that manages the patient’s diabetes must sign the comprehensive plan of care before the shoes and inserts can be dispensed by the podiatrist.

DURABLE MEDICAL EQUIPMENT. The Plan will pay as stated in the “Summary of Benefits and Coverage”, for the rental of certain Hospital-type equipment, including, but not limited to, a wheelchair, a Hospital-type bed, or mechanical equipment for the treatment of respiratory paralysis.

Also covered are charges for oxygen and the equipment for the administration of oxygen, for the personal and exclusive use of the patient.

The total covered expense for renting Durable Medical Equipment shall not exceed its purchase price. If the cost of renting the equipment is more than a Covered Person would pay to buy it, the cost of the purchase will be considered a covered expense. Excluded in this provision are equipment or devices not specifically designed and intended for the care and treatment of an Injury or Sickness.

ELECTIVE STERILIZATION PROCEDURES. Charges incurred for Vasectomies and Tubal Ligations, but not for the reversal of the same operations.
HEARING LOSS. Upon Medical Director review and pre-certification, this Plan covers the services of a local, in-network otolaryngologist (ENT) for the care or treatment of hearing loss, but only in cases where treatment is necessary as the direct result of an Accidental Injury or Illness.

HOME HEALTH CARE. Charges incurred for necessary Home Health Care will be paid as shown in the “Summary of Benefits and Coverage”, subject to the requirements and benefit maximum(s) shown.

Charges for the following services: part-time or intermittent nursing care by or under the supervision of a Registered Nurse (R.N.); visits by persons who have completed a home health aide training course under the supervision of a registered Nurse; Physical Therapy, Occupational Therapy, and Speech Therapy; medical supplies, drugs and medications prescribed by a Physician and, laboratory services, to the extent such items would have been covered under the Plan if the Covered Person had been hospitalized.

Each visit by a member of a Home Health Care team is considered as one Home Health Care visit and 4 hours of home health aide services is considered as one Home Health Care visit. However, benefits are not payable for Custodial Care or transportation services.

HOSPICE CARE. The Plan will pay for the charges made by a formal in-network Hospice Program directed by a Physician to help care for a Terminally Ill covered individual when the attending Physician certifies life expectancy is 12 months or less. Benefits will be paid as shown in the “Summary of Benefits and Coverage”, subject to the requirements and benefit maximum(s) shown.

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

Hospice Care includes Inpatient care in a Hospice, a Hospital or a home care setting. Outpatient services provided by the hospice include drugs or medical supplies. Also included are instructions for care of the patient, counseling, and other supportive services for the family of the dying individual.

HOSPITAL SERVICES

- **Room and Board Charges**
  Benefits are payable for daily Room and Board not to exceed the amount shown in the “Summary of Benefits and Coverage”. The room limit for each day of confinement in a private room is the daily Average Semi-Private Room Rate. However, if a private room is Medically Necessary due to contagious disease, the Hospital's Usual, Reasonable and Customary charge for such room will be a covered expense.

- **Inpatient Hospital Special Charges**
  Benefits are payable for the Hospital's special charges and for non-custodial services of a Nurse when rendered on an Inpatient basis.

- **Intensive Care**
  Payment will be made for confinement in an Intensive Care, cardiac care or neonatal unit up to the amount shown in the “Summary of Benefits and Coverage”.

14
COVERED MEDICAL EXPENSES (Continued)

Intensive Care must be: (a) ordered by a Physician; and (b) due to a condition that requires special medical and nursing treatment not generally provided to other Inpatients of the Hospital.

For determining the benefits payable, all care in a Hospital shall be considered related and to have occurred in one "Period of Confinement" (as defined in the “Definitions” section of This Plan).

INPATIENT DOCTOR’S VISITS. The Plan will cover the charges for Physician visits (including specialists), to the patient while in the Hospital or Special Care Facility.

MAMMOGRAPHY SCREENING. The Plan will pay for mammography as shown in the “Summary of Benefits and Coverage”. This is not limited to, but will include the following:

1. Benefits will be paid for the baseline mammogram for a patient who is at least thirty-five (35) but less than forty (40) years of age.
2. Benefits will be paid for no more than one (1) screening mammogram every year for a patient who is at least forty (40).

MASTECTOMY PROCEDURES (related to the diagnosis of breast cancer pursuant to the Women’s Health and Cancer Rights Act of 1998). The Plan shall cover the following procedures in the manner as determined in consultation between the attending Physician and the covered Employee or Dependent:

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

All Pre-certification and Utilization Review requirements of the Plan will not apply to Surgical and treatment procedures associated with mastectomies of the covered Employee or covered dependent.

MATERNITY. Maternity benefits and benefits for complications of Pregnancy are payable on the same basis as any other Illness for Covered Employees and Covered Dependents.

All mothers and newborns may have a minimum of a 48 hour hospitalization after a normal birth and a hospitalization of a minimum of 96 hours after a Cesarean delivery. Patients may make a decision to leave a Hospital sooner. This decision should be mutually agreed upon between the Physician and the mother.

MEDICAL SERVICES AND SUPPLIES Charges incurred for: (a) casts, splints, cervical collars, head halters, traction apparatus, trusses, braces, crutches, catheters, colostomy bags, and surgical dressings; (b) the purchase of custom orthotic devices to be attached to or placed in shoes (but not the shoes themselves), (c) the initial purchase of eyeglasses or contact lenses due to cataract Surgery; (d) the initial purchase of a wig after chemotherapy, and (e) initial purchase of two mastectomy bras, limited to two per calendar year.
COVERED MEDICAL EXPENSES (Continued)

MENTAL OR NERVOUS DISORDERS. Benefits will be paid as shown in the “Summary of Benefits and Coverage” for treatment of Mental or Nervous Disorders.

A Mental Disorder must be classified in the International Classification of Diseases of the U.S. Department of Health and Human Services and must, according to generally accepted professional standards, be amenable to favorable modification. Coverage will not extend beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation. No benefits are provided for court ordered or license mandated treatment of mental or psychiatric disorders.

Treatment of Mental and Nervous Disorders must be given under the direction of a Physician and the treatment program must be accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) or by equal standards.

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

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

- **Day Treatment**
  The Plan will pay for charges incurred if treatment involves Day Treatment or a combination of Inpatient and Day Treatment.

NEWBORN BABY CARE. Newborn Well-baby Care includes charges made during the initial Hospital confinement for Hospital nursery room, board, miscellaneous services and supplies and physician charges for circumcision and routine exams of the child before release from the Hospital. A covered newborn who is sick or injured is eligible for benefits to the same extent as any other covered person. This includes treatment of diagnosed birth defects, congenital anomalies, and abnormalities.

OFFICE VISITS. The Plan covers the services of Physicians and Surgeons seen by the Covered Person for the diagnosis and treatment of an Illness or Injury as shown in the “Summary of Benefits and Coverage”.

ORGAN OR TISSUE TRANSPLANT SERVICES. Eligible charges for human organ and tissue transplants are covered as specified on the Schedule of Benefits if the transplant procedure is not Experimental or Investigational. When a donor or recipient is involved, charges are covered as follows:

1. When both the recipient and the donor are covered by the Plan, each is entitled to benefits under the Plan;
2. When only the recipient is covered by the Plan, the covered person who is the recipient is entitled to the benefits under the Plan and the donor is entitled to certain limited benefits as specified by the Plan. In this instance, for the donor, only those
eligible charges for services to donate the human organ or tissue will be covered. The donor will be eligible for these specified benefits under the Plan only if such charges are not covered for the donor from any other source, including for example, any insurance coverage, employee benefit plan or government program. Eligible donor charges covered by the Plan will accumulate toward any maximum applicable to the covered person who is the recipient; or

3. When only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan, however, any other source of coverage available to the donor will be considered the primary payor of benefits and this Plan will be the secondary payor of benefits. No benefits are provided to the non-covered transplant recipient.

4. Eligible charges related to an organ or tissue transplant include for example hospitalizations, supplies and medications which are dispensed while either an inpatient or outpatient in a medical facility and those related to the evaluation and/or procurement of the organ or tissue. Benefits will not be duplicated if they are available from another plan, an organization or Medicare.

Specified Transplant Covered Expenses

If the employer uses a reinsurance carrier that offers a transplant network of providers, there may be special transplant benefits available for utilizing transplant network providers.

Transportation will be provided for the recipient if the nearest network facility is outside a 250 mile radius. In the event of an emergency, the 250 mile radius will be waived. No coverage will apply for lodging and/or meals for the donor, the recipient, or their families.

Nearest network facility means the contracted participating facility, which is closest in miles to the principle residence of the covered person.

OCCUPATIONAL THERAPY. The Plan will pay for the services of a Registered Occupational Therapist, for therapy ordered by a Physician and deemed Medically Necessary. The patient must demonstrate functional gains; Occupational Therapy for the sole reason of maintaining current level of functioning and to prevent deterioration is not a covered benefit.

The therapist must be under the direct supervision of a Physician in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly-licensed Outpatient therapy facility.

OXYGEN. The Plan will pay for charges for: oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment. See Durable Medical Equipment.

OUTPATIENT SURGICAL FACILITY. If you have Surgery done at an approved Outpatient Surgical Facility, those charges are Covered Expenses. Coverage is provided for miscellaneous services and supplies rendered by the facility on its own behalf. This includes charges made by a Doctor for services rendered while you are at the facility, for x-rays and lab tests, and for radiology and pathology. These charges are covered whether billed directly by the facility or separately by the Doctor.
COVERED MEDICAL EXPENSES (Continued)

PHYSICAL THERAPY. The Plan will pay for the services of a Registered Physical Therapist, for therapy ordered by a Physician and deemed Medically Necessary. The patient must demonstrate functional gains; Physical Therapy for the sole reason of maintaining current level of functioning and to prevent deterioration is not a covered benefit.

The therapist must be under the direct supervision of a Physician in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly-licensed Outpatient therapy facility.

PREVENTIVE CARE/ROUTINE PHYSICAL EXAM. The Preventive Care/Routine Physical Exam Benefit includes, but is not limited to, pap smears, prostate specific antigen tests, gynecological examinations, immunizations, routine physical examinations, x-rays and laboratory blood tests.

PROSTHETICS. The Plan will pay for charges for the initial purchase of artificial eyes and limbs for the initial replacement of natural eyes and limbs, or for the replacement of such prosthesis if it is determined to be necessary, by the Covered Person's Physician, because of growth or bodily change; purchase of a breast prosthesis for the replacement of a breast surgically removed.

RESPIRATORY THERAPY. Professional services of a licensed respiratory therapist when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

SECOND AND/OR ADDITIONAL MEDICAL/SURGICAL OPINION BENEFITS (Voluntary). The Plan will pay for charges (in accordance with Plan Benefits) incurred by a Covered Person in obtaining a second and/or additional medical/surgical opinion, after he or she has decided to undergo a Medical/Surgical Procedure which is covered under this Plan. A second and/or additional opinion regarding cosmetic surgery, normal obstetrical delivery and surgical procedures which require only local anesthesia are not covered.

Benefits include the Physician's charges for the physical examination, laboratory work, x-rays and related tests not previously performed by the original physician. If the second opinion does not confirm the original recommendation, the Covered Person may consult another Physician (in accordance with Plan Benefits) for an additional opinion.

SKILLED NURSING FACILITY. This benefit is payable when you are confined to a Skilled Nursing Facility because of an Injury or Sickness covered by The Plan. Covered Expenses include room and board (limited to the average semi-private room rate in the facility), routine services, and skilled nursing care. Benefits for a Skilled Nursing Facility confinement will not be payable if the confinement is for Custodial Care.

The Physician must certify that confinement in a Skilled Nursing Facility is in lieu of Hospital confinement and must submit a written treatment plan which establishes the medical necessity for the service.

SLEEP DISORDER/SLEEP APNEA. Benefits will be paid for the diagnosis and treatment of sleep disorders/sleep apnea by a certified Sleep Apnea Specialist.
COVERED MEDICAL EXPENSES (Continued)

SPEECH THERAPY - RESTORATIVE OR REHABILITATIVE. The Plan will pay for the services of a legally Qualified Speech Therapist for therapy ordered by a Physician and deemed Medically Necessary. The patient must demonstrate functional gains; Speech Therapy for the sole reason of maintaining current level of functioning and to prevent deterioration is not a covered benefit.

The therapist must be under the direct supervision of a Physician in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly-licensed Outpatient therapy facility.

SURGERY. The Plan will cover the charges made by a Physician for the performance of surgical procedures deemed Medically Necessary.

The Plan provides benefits for the services of an assistant surgeon provided the assistance is Medically Necessary and no intern, resident, or other staff Physician is available. The amount considered as eligible charges for an assistant surgeon is the lesser of the assistant surgeon's fee or no more than 20% of the allowable charge for the surgical procedure.

Sometimes the Physician may perform more than one Surgical Procedure in one operating period. Multiple Surgical Procedures can often be done through the same natural or separate body openings, or through the same incision in the same operative field. In such a case, the maximum benefit will be allowed for the primary procedure. One-half of the allowable benefits will be paid for each of the next three (3) lesser procedures, provided that they are not incidental procedures. No additional amount will be allowed for an incidental procedure when performed in conjunction with other major Surgical Procedures.

Sterile surgical supplies after Surgery are also covered.

The Physician's fee for a procedure is deemed to include all post-operative care he or she gives for the same condition.

TEETH, GUMS AND ALVEOLAR PROCESS. This Plan covers the services of a licensed in-network dental surgeon for the care or treatment of the teeth, gums, or alveolar process but is limited to:

a. The excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when a lab exam is required;
b. The removal of impacted teeth, including soft tissue, partial bony, full bony, and related services;
c. External incision and drainage of cellulitis;
d. Incision of salivary glands or ducts;
e. Emergency repair for Accidental Injuries to natural teeth; and
f. Surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
g. Anesthesia for any of the above services, administered by a network provider only.

When treatment is necessary as the direct result of an Accidental Injury, eligible Hospital expenses and expenses incurred for the services of a licensed dental surgeon are also covered.
COVERED MEDICAL EXPENSES (Continued)

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ). Benefits will be paid as shown in the “Summary of Benefits and Coverage” for charges incurred for surgical and non-surgical treatment of temporomandibular joint disorders and craniomandibular disorders on the same basis as for treatment to any other joint in the body, provided the treatment is administered by a network Physician.

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

Allergy therapy for the treatment of allergies by the administration of antigens is considered to be a covered charge based on the type and number of antigen doses per vial.

WEIGHT MANAGEMENT CHARGES. Benefits are payable for the charges associated with Weight Management. Member must meet specific requirements and adhere to the Program’s regimen.

WELL CHILD CARE. The Plan shall cover Well Child Services provided by a Physician from birth to age eighteen. Benefits will be covered in full at the plan allowable as shown in the “Summary of Benefits and Coverage”.

Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics and the Patient Protection and Affordable Care Act.
MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS

The Plan will not pay for, and Covered Medical Expenses do not include:

1. **Abortion.** Non-therapeutic abortions, whether for the Covered Employee, Covered Spouse or Covered Dependent Child, unless: (1) the mother’s life would be endangered if the pregnancy were allowed to continue to term; (2) an amniocentesis and genetic testing of fetal chromosomes has shown one or more severe congenital abnormalities such as Down’s Syndrome, or; (3) the pregnancy resulted from an act of rape or incest; (4) fetal reduction (triplets or more);

2. **Abortion Complications.** Charges for complications arising from any non-covered surgery or treatment;

3. **Adoption.** Any charges for adoption expenses or services of a surrogate mother;

4. **Alternative Treatment.** Charges for holistic medicine, acupuncture, hypnosis or biofeedback or other forms of self-care or self-help;

5. **Appointments.** Expenses for broken appointments or telephonic appointments/calls;

6. **Artificial Heart and other Artificial Organs.** Expenses related to insertion or maintenance of an artificial heart, or other artificial organs;

7. **Automobile Personal Injury Protection Insurance.** Expenses related to an Injury or Illness for which the Covered Member is entitled to benefits or payments pursuant to any No-Fault type automobile reparations ordinance or statute;

8. **Autopsy.** Charges for services associated with autopsy or postmortem examination, including the autopsy;

9. **Claims (timely filing).** Charges for claims not received within twelve (12) months from the date services were incurred;

10. **Claims (denials).** For any expense denied by the Primary Health Plan because the claim did not comply with the rules governing that plan of benefits;

11. **Colonoscopies.** Charges for routine screening colonoscopies for covered members under age 50, unless deemed medically necessary;

12. **Contraceptives.** Charges for over-the-counter contraceptive supplies;

13. **Cosmetic Drugs.** Charges for Minoxidil (Rogaine) for the treatment of alopecia or any other drug used primarily for cosmetic purposes;

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

15. **Counseling.** Charges for marital or family counseling;
16. **Custodial Care/Private Duty Nursing.** Charges for custodial care, private duty nursing or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training. Any type of maintenance care which is not reasonably expected to improve the patient’s condition except as may be included as part of a formal Hospice care program;

17. **Dental.** Charges for dental services and supplies where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth. (except as specified under the “TEETH, GUMS AND ALVEOLAR PROCESS” provision of This Plan (see Page 18);

The following two categories of services are excluded from coverage:

1. A primary service (regardless of cause or complexity) provided for the care, treatment, removal, or replacement of teeth or structures directly supporting teeth, e.g., preparation of the mouth for dentures, removal of diseased teeth in an infected jaw.

2. A secondary service that is related to the teeth or structures directly supporting the teeth unless it is incident to and an integral part of a covered primary service that is necessary to treat a non-dental condition (e.g., tumor removal) and it is performed at the same time as the covered primary service and by the same physician/dentist. In those cases in which these requirements are met and the secondary services are covered, the Plan does not make payment for the cost of dental appliances, such as dentures, even though the covered service resulted in the need for the teeth to be replaced, the cost of preparing the mouth for dentures, or the cost of directly repairing teeth or structures directly supporting teeth (e.g., alveolar process).

Exceptions to Services Excluded:

1. The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.

2. An oral or dental examination performed on an inpatient basis as part of comprehensive workup prior to renal transplant surgery or performed in a RHC/FQHC prior to a heart valve replacement.

18. **Diabetic Shoes.** Charges for diabetic shoes and/or inserts dispensed by a non-contracted provider. For further details, see Diabetic Footwear under Covered Medical Expenses.

19. **Equipment.** Charges for purchase or rental of motorized transportation equipment (motorized chairs, electric wheelchairs); wheelchair lifts; escalators or elevators; saunas or swimming pools; structural changes to a house or vehicle; professional medical equipment such as blood pressure kits; or supplies or attachments for any of these items;

20. **Experimental or Investigational.** Treatment, procedure, drug, device, or technology as to which the Plan Administrator or its designee has determined that any of the following applies (at the time it makes a determination regarding Coverage):
MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS
(Continued)

1. It cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not been given at the time of treatment, procedure, drug, or device is furnished; or

2. It is subject to review and approval by the treating facility’s institutional review board, or other institutional review board; or

3. Reliable Evidence shows that to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis for the condition in question: A) It is undergoing phase, I, II, or III clinical trials (as defined by FDA regulations, regardless of whether the trial is subject to FDA oversight), or is under study; or B) Further clinical trials or studies are needed according to the experts’ consensus opinion. “Reliable Evidence” means published reports and articles in authoritative medical and scientific literature; or the written protocol or protocols used by the treating facility, or by another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility, or by another facility studying substantially the same drug, device, medical treatment or procedure. In determining whether benefits should be excluded, the prevailing criteria for consideration will be whether the service is recognized as standard medical care for the condition, disease, illness or injury being treated;

21. Eye Examinations. Charges for eye exams or eye refractions (to determine the correction of vision); charges for eye exercises or eyeglasses or contact lenses or their fitting, except as prescribed by an Ophthalmologist in connection with the treatment of cataracts; for orthoptics, vision therapy or supplies; for Radial Keratotomy or other refractive Surgery; Note: This exclusion will not apply to the initial purchase of glasses or contact lenses following cataract surgery;

22. Foot Care. Charges for the following care: Over the counter footwear and supplies;

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

24. Government Services and Supplies. Charges for care, treatment, services, and supplies provided or paid for by any government plan or law not restricted to its own civilian employees and their dependents (This will not apply to Medicaid or the Uniformed Services Employment and Reemployment Rights Act of 1994);
25. **Hair Transplantation.** Charges for transplantation and other procedures to replace lost hair or to promote the growth of hair, for the use of Monoxidil, Propecia, Rogaine, or other prescription drugs or medicines used to promote the growth of hair, or for hair replacement devices including but not limited to wigs, toupees and/or hairpieces, **except** that the EPO Plan will provide benefits for a single wig, toupee or hairpiece if it is required to replace hair lost as a result of chemotherapy or radiation therapy or in the case of hair lost as a result of certain childhood diseases causing permanent hair loss;

26. **Hearing Examinations.** Charges for hearing examinations, hearing aids, their fitting, or related supplies;

27. **Illegal Activities.** Charges for or in connection with an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection, or civil disturbance, or being engaged in an illegal occupation or the commission or attempted commission of an illegal or criminal act;

28. **Implant Removal.** Charges for expenses related to the removal of breast or other prosthetic implants are excluded unless determined to be Medically Necessary;

29. **Infertility.** Charges for all services and supplies for and/or related to treatment of infertility, artificial insemination, zygote intrafallopian transfer, in-vitro fertilization or embryo transfer procedures except for diagnostic testing to determine infertility;

30. **Intervention Project for Nurses/Professional Resource Network (IPN/PRN) and other related Programs to retain medical licensure.** Charges for all services related to treatment;

31. **Massage Therapy.** Charges for Massage Therapy or rolling;

32. **Medical Reports.** Expenses for preparing medical reports, itemized bills or claim forms, mailing and/or shipping and handling;

33. **Medically Necessary.** Charges for any medical treatment not generally accepted as Medically Necessary for diagnosis or treatment of a Covered Person's Sickness or Injury; for any care, treatment, services, and supplies not recognized throughout the medical profession as appropriate for treating the Covered Person's Sickness or Injury even if ordered by a doctor; or for care, treatment, services and supplies not prescribed by or performed by or upon direction of a Physician or Practitioner;

34. **Military Activities.** Charges incurred due to a declared or undeclared act of war, or any act due to war, arising from any other military activities including offensive, defensive, peacekeeping or training activities;

35. **Outside of United States.** Charges for treatment or services rendered outside the continental United States of America or its territories except for an Accidental Injury or a Medical Emergency;
MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS
(Continued)

36. **Over the Counter Medications.** Charges for prescription drugs, medicines, supplies, vitamins (including prenatal vitamins), mineral supplements, or fluoride drugs, whether or not a Physician's prescription is required;

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

38. **Private Duty Nursing/Custodial Care.** Charges for private duty nursing, custodial care, or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training. Any type of maintenance care which is not reasonably expected to improve the patient’s condition except as may be included as part of a formal Hospice care program;

39. **Professional Resource Network/Intervention Project for Nurses (PRN/IPN) and other related Programs to retain medical licensure.** Charges for all services related to treatment;

40. **Professional Medical Services.** Charges for professional medical services and supplies rendered by the Employee, Employee’s Spouse, or the children, brothers, sisters, parents or grandparents of either the Employee or the Employee’s Spouse;

41. **Rehabilitative Services.** Charges for rehabilitative services such as recreational therapy, or any similar services by whatever name, expect as otherwise stated;

42. **Sexual or Gender dysfunctions.** Charges for sex change Surgery; penile prosthetic implant; services, therapy or counseling for sexual or gender dysfunctions or inadequacies. Exception: penile prosthesis/vacuum device when due to recognized medical indications. Psychological indications are not covered;

43. **Smoking Deterrent.** Charges for smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g. Nicorette, Nicoderm, etc.);

44. **Spinal Manipulation/Spinal Decompression.** Charges for manipulation of the spine requiring Anesthesia or for Non-Surgical Spinal Decompression;

45. **Sterilization.** Charges for reversal of any sterilization procedure;

46. **Termination of Coverage.** Charges for any benefit or service provided after Coverage has been terminated (last day worked) for the group or for the Participant, or after Coverage has been canceled;

47. **Transplants.** Charges for transplants, except as stated in the Organ or Tissue Transplant Services section of Covered Expenses (Page 16);
MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS
(Continued)

48. **Travel Expenses.** Charges for travel, travel time or accommodations, whether or not recommended by a Physician; or for related expenses by an eligible provider of services, or for medical services rendered outside the continental United States of America or its territories except for Accidental Injury or a Medical Emergency;

49. **Treatment of Family Members.** The expenses that constitute from generated charges for the treatment of immediate relatives of the beneficiary (Physician) are not eligible for reimbursement by the Plan. The intent of this exclusion is that payment for such items and services would ordinarily be furnished gratuitously. Immediate Relative – the following degrees of relationship are included within the definition of immediate relative, but not limited to: husband and wife; natural or adoptive parent, child, and sibling; stepparent, stepchild, stepbrother, and sibling; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law and sister-in-law;

50. **Unauthorized Charges.** Charges for which you are not legally required to pay (including any charges that are discounted or rebated), or for professional services rendered by a family member; charges which you would not have to pay if you had no Coverage, or any expenses incurred while you are not covered under this Plan;

51. **Unauthorized Hospitalization.** Charges for Hospital service for a Participant who remains in a Hospital after the attending Physician advises that further Hospital services are unnecessary;

52. **Urgent Care Centers.** Any charges for services rendered.

53. **Usual, Reasonable and Customary.** Charges which are in excess of the maximum Network Allowable;

54. **Vocational Testing or Training.** Vocational testing, evaluation, counseling or training;

55. **Weekend Non-Emergency Hospital Admissions.** Charges for Weekend Non-Emergency Hospital Admissions (an Admission to a Hospital on a Friday, Saturday or Sunday at the convenience of the Covered Person or his or her Physician when there is no cause for an emergency Admission and the Covered Person receives no surgery or therapeutic treatment until the following Monday or later);

56. **Weight Control.** Charges for weight control services including any service to lose, gain or maintain weight regardless of the reason for the service. See “Summary of Benefits and Coverage” for exceptions;

57. **Workers' Compensation.** Charges for any Injury or Sickness arising out of any activity for wage or profit by the Covered Person. This includes self-employment or employment by others. It applies whether or not Workers' Compensation or similar law covers the expenses incurred.
GENERAL CLAIM PROVISIONS

TIME LIMIT FOR SUBMITTING CLAIMS. All claims should be submitted as soon as possible after the charges are incurred. In any event, all claims must be submitted within one (1) year (12 months) of the date charges are incurred to be considered eligible for payment. A charge will be deemed to be incurred on the date services are actually rendered or supplies are actually received.

ASSIGNMENT OF BENEFITS. Benefits payable by the Plan are assigned directly to the provider of services. It is the provider’s choice to accept assignment of benefits. In cases where the provider chooses not to accept assignment, the member will be responsible for payment in advance and benefits will be paid to the member according to the maximum Volusia Health Network plan allowable.

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

RIGHT TO INVESTIGATE CLAIMS. The Plan Administrator acting on its behalf retains the right to request any medical information from any provider of service it deems necessary to properly process a claim.

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

FREE CHOICE OF PHYSICIAN. Any covered Employee or Dependent will have their choice of network Physicians.
FILING A CLAIM FOR BENEFITS

The appropriate claim forms and identification cards may be obtained directly from your Employer. The following general steps should be followed in order to file a claim. Detailed instructions for filing claims are included on the claim form. Claim forms should be updated yearly or more often if members have a change in status.

1. Complete the Employee portion of the Volusia Health Network claim form in full. Answer all questions, even if the answer is "none" or "N/A" (does not apply).

2. Complete the Dependent section of the claim form for each Covered Person for whom benefits are being requested.

3. Attach all necessary original receipts to the claim form. Receipts for claims must include: the diagnosis; procedure codes; the date(s) of service; the patient's name; the provider's name, address, phone number; the National Provider Identification number and the federal tax identification number of the provider.

4. If another plan is the primary payor, a copy of the other plan's Explanation of Benefits (EOB) must accompany the claim form sent to Volusia Health Network.

5. If the provider is to be paid directly, sign the "Authorization To Pay Benefits To Provider(s)" portion of the claim form.

6. Sign, date and mail (or e-mail) the completed claim form to:

   VOLUSIA HEALTH NETWORK • P.O. Box 2814 • Daytona Beach, FL 32120
   vhn.staff@halifax.org

CLAIM DENIAL AND HOW TO APPEAL A DENIAL OF BENEFITS

If you believe a claim was improperly settled, in whole or in part, you have the right to appeal the claim settlement by making a written request for review within 180 days (6 months) of paid date.

You have the right to review this Employee Medical & Dental Benefits Handbook and other papers affecting the claim. You also have the right to have a representative act on your behalf in the appeal.

The Plan will review the processed claim, and any supporting documents such as letters from your physician, and inform you in writing as to their decision within 60 days. In the event a claim is denied, the Covered Person will be advised of the reason for the denial with specific reference to The Plan provision(s) on which the denial was based.

If you are not satisfied with the first review, a written request for a second review may be submitted. The Plan may request additional material or any other information needed for review, including medical records and additional supporting letters from your physician. You must submit your request for a second review keeping within the 180 days (6 months) of paid date. The request should state, in clear and concise terms, the reason for disagreement with the way the claim was processed.

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

GENERAL PROVISION. When you and/or your Dependents are covered under more than one group health or dental plan, the Coverage under This Plan will be coordinated with the Coverage under the other Employer's plan. One plan will pay benefits based partly on what the other plan pays. Please submit a completed claim form.

The plan that considers the expenses first is called the primary plan. The plan that waits for the primary plan to consider the expenses is called the secondary plan.

For purposes of coordination, eligible expense means any applicable network fee schedule considered in part or full by at least one of the plans. However, any expense denied by the primary carrier because the participant did not comply with the rules governing the plan of benefits will not be considered as eligible under our Plan.

DETERMINING PRIMARY/SECONDARY COVERAGES. This Plan coordinates with other plans according to the following rules:

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

CHILDREN OF DIVORCED OR SEPARATED PARENTS. When all plans covering a person as a Dependent child of divorced or legally separated parents contain a coordination of benefits provision, This Plan coordinates with other plans according to the following rules:

1. If there is a court order establishing which parent has financial responsibility for the child's health care expenses, that parent's plan (assuming it covers the child as a Dependent), will be primary.
2. If there is no court order, and the parent with legal custody has not remarried, that parent's plan is primary (assuming it covers the child as a Dependent).
3. If there is no court order, and the parent with legal custody has remarried, the plan that covers the child as a Dependent will pay benefits in the following order:
   a. The plan of the parent with legal custody;
   b. The plan of a step-parent who is the spouse of the natural parent having legal custody;
   c. The plan of the parent without custody.
COORDINATION OF BENEFITS (Continued)

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

INTEGRATION OF BENEFITS WITH MEDICARE/MEDICAID. For an Active Employee who is age 65 or over, the benefits payable under this Plan will be his or her primary health coverage unless he or she elects, in writing, to have Medicare as primary coverage. Any Employee who elects Medicare as primary coverage will not be covered for health coverage under this Plan, nor will any of his or her Dependents.

For a legally married Spouse of an Active Employee who is covered as a Dependent under this Plan and who is age 65 or over, the benefits under this Plan will be his or her primary health coverage unless he or she elects, in writing, to have Medicare as primary coverage.

For any Totally Disabled Employee or Dependent who is under age 65, the benefits under Medicare will be secondary to any benefits payable under this Plan.

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

The benefits of This Plan are payable before Medicaid. However, This Plan will coordinate benefits with Medicaid so that the combined benefits of both plans do not exceed the normal covered percentage payable for eligible Covered Expenses in This Plan.

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION. The Plan Administrator has right to give information to or obtain information from any insurance company, organization or person regarding any Covered Persons. As a claimant under This Plan, the Covered Person must supply the Plan Administrator with information necessary to enforce this provision.

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

RIGHT OF RECOVERY. If more benefits were paid than should have been, the right to recover the excess amount will be exercised. This can be from the person for whom the payments were made or from any other insurance company or organization. The Plan has the right to withhold payment on future benefits until the overpayment is recovered.
SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY PROVISION

WHEN THIS PROVISION APPLIES: If you, your spouse, one of your dependents, or anyone who receives benefits under this plan becomes ill or is injured and is entitled to receive money from any source, as allowed by law, including but not limited to: payments made by a third-party tortfeasor or any insurance company on behalf of the third-party tortfeasor, any party’s liability insurance or uninsured/underinsured motorist proceeds, any worker’s compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; any other payments from a source intended to compensate an employee or covered person for injuries resulting from an accident or alleged negligence, then the Plan retains the right to repayment of the cost of all benefits provided by the Plan on behalf of the employee or covered person that are associated with the injury or illness for which another party is or may be responsible, as allowed by law. The benefits provided or to be provided by the plan are secondary, not primary, and will be paid only if you fully cooperate with the terms and conditions of the plan.

As a condition of receiving benefits under this plan, the employee or covered person agrees that acceptance of benefits is constructive notice of this provision in its entirety and acknowledges the Plan’s right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when the Plan has provided health care benefits for injuries or illness for which another party is or may be responsible and the employee or covered person and/or the employee or covered person’s representative has recovered any amounts from the third party or any part making payments on the third party’s behalf. This right of reimbursement is a first-priority claim. The person receiving benefits further agrees that any funds received by said person and/or their attorney, if any, from any source for any purpose shall be held in trust until such time as the obligation under this provision is fully satisfied. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor’s trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor’s representative has access or control of any recovery funds. The Plan’s right of reimbursement is cumulative with, and not exclusive of, the Plan’s subrogation right. The Plan may choose to exercise either or both rights of recovery.

The employee or covered person specifically acknowledges the Plan’s right of subrogation, and that this right is a first-priority claim. When the Plan provides health care benefits for injuries or illnesses for which a third party is or may be responsible, the Plan shall be subrogated to the employee or covered person’s rights of recovery against any party to the extent of the full cost of all benefits provided by the Plan, to the fullest extent permitted by law. The Plan may proceed against any party with or without the employee or covered person’s consent.

The employee or covered person agrees to sign any documents requested by the Plan including but not limited to reimbursement and/or subrogation agreements as the Plan or its agent(s) may request. Also, the employee or covered person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan.
The employee or covered person agrees to take no action which in any way prejudices the rights of the plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against the employee or covered person, then the employee or covered person agrees to pay the Plan’s attorney’s fees and costs associated with the action as permitted by law.

The Plan Sponsor has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary.

If the employee or covered person takes no action to recover money from any source, then the employee or covered person agrees to allow the Plan to initiate its own direct action for reimbursement.
GENERAL PLAN PROVISIONS

WAIVER. The failure of the Plan Administrator to strictly enforce any provision of This Plan shall not be construed as a waiver of the provision. The Plan Administrator reserves the right to strictly enforce each and every provision of This Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

EFFECTIVE DATE OF CHANGE IN AMOUNT OF COVERAGE. Any change in the amount of Coverage of a Covered Person by reason of a change in classification, change in benefits structure and/or schedule, or for any other reason, will become effective on the first day of the next month.

CONFORMITY WITH LAW. This Plan shall be deemed automatically amended to conform to the minimum requirements of the applicable Florida Statutes as may be amended from time to time. If any provision of This Plan conflicts with any other law to which it is subject, such provision shall be deemed automatically amended to conform to the minimum requirements of any such law. If any provision of This Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

WRITTEN NOTICE. Any written notice required under This Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over This Plan shall be interpreted to conform to the minimum requirements of such law.

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

USE OF STATEMENTS. No statement made by or on behalf of any person shall be used in any context unless a copy of the written instrument containing such statement has been or is furnished to such person or to any person claiming a right to receive benefits with respect to such person.

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

MISSTATEMENTS ON APPLICATION. If any relevant fact has been misstated by or on behalf of any person to obtain Coverage under This Plan, the true facts shall be used to determine whether Coverage is in force and the extent, if any, of such Coverage. Upon the discovery of any such misstatement, an equitable adjustment of any contributions will be made.

TIME LIMIT FOR MISSTATEMENT. No Misstatement made to obtain Coverage under This Plan shall be used to void the Coverage of any person which has been in force for a period of two (2) years or to deny a claim for a loss incurred or disability commencing after the expiration of such two (2) year period. The provisions of the paragraph shall not apply if any such misstatement has been made fraudulently.
NOT A CONTRACT. This Plan shall not be construed as a contract, consideration, or inducement of employment, or as affecting in any manner or to any extent whatsoever the rights or obligations of the Employer or any Employee to continue or terminate employment at any time.

CLERICAL ERROR. If a clerical error is made, it will not affect the Coverage to which the Covered Person is entitled. A fair adjustment of premiums shall be made when a clerical error pertaining to the Coverage under The Plan is found in keeping the records of The Plan or a delay in making entries on the records pertaining to The Plan. Such an error or delay will neither void Coverage that is otherwise validly in force, nor continue Coverage beyond the date that Coverage would otherwise have been reduced or terminated.

LEGAL PROCEEDING. Legal actions to recover any lost benefits under This Plan may not be brought until The Plan's appeal procedure, including utilization of a professional/peer review committee, has been exhausted per the terms of the applicable Florida Statutes, not later than three (3) years after the expenses/disability were incurred.

AUTHORITY AND DISCRETIONARY CONTROL OF THE PLAN. The Plan Administrator, and/or its designated administrative agents or representatives, shall have full power and authority and absolute discretion to determine all questions of eligibility for benefits of all claimants, and to interpret and construe the terms of The Plan. Such determinations, upon proper and adequate review, shall be conclusive and binding upon all interested parties.

REPLACEMENT OF ANOTHER PLAN. If This Plan of benefits replaces the Employer's prior plan of group health benefits, and if an Employee or a Dependent (a) becomes covered by this Plan on its effective date, and (b) had been covered by the Employer's prior plan of group health benefits on the day before This Plan took effect:

1. Credit will be given for any amounts applied to the prior plan's Calendar Year Deductible and Out-of-Pocket Amount(s); and

2. Benefits under this Plan will not be payable for any expenses being paid by the prior plan under an Extension of Benefits provision.

IN THE EVENT OF AN ACQUISITION OR MERGER. In the event of an acquisition or merger, the Plan Administrator shall have full power and authority and absolute discretion to waive the Waiting Period and any Pre-Existing Conditions Limitations of This Plan for Employees and Dependents.

If the Plan Administrator elects to extend Coverage under This Plan to a newly acquired affiliated and/or associated company; and if This Plan replaces the prior plan of group health coverage of the newly acquired affiliated and/or associated company; and if an Employee or a Dependent;
GENERAL PLAN PROVISIONS (Continued)

(a) Becomes covered by This Plan on the date Coverage is assumed by This Plan, and (b) had been covered by the prior plan of group health benefits on the day before Coverage was assumed by This Plan:

1. Credit will be given for any amounts applied to the prior plan's Calendar Year Deductible and Out-of-Pocket Amount(s); and

2. Benefits under This Plan will not be payable for any expenses being paid by the prior plan under an Extension of Benefits provision.

AMENDING AND TERMINATING THE PLAN. The Employer intends The Plan to be permanent, but since future conditions affecting the Employer cannot be anticipated or foreseen, a person, who is authorized to act on behalf of the Employer, reserves the right to amend, modify, suspend or terminate The Plan in whole or in part at any time by formal written action. This includes, but is not limited to, amending the benefits, Deductibles, maximums, Co-Payments, exclusions, limitations, definitions or eligibility under The Plan or the Trust Agreement (if any). If The Plan is terminated or amended to reduce or terminate certain benefits, the rights of the Covered Persons to benefits are limited to expenses incurred prior to termination or Amendment.

RIGHT OF RECOVERY. If more benefits were paid than should have been, the right to recover the excess amount will be exercised. This can be from the person for whom the payments were made or from any other insurance company or organization.

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

NOTICE OF SELF-FUNDED DISCLOSURE. The health Coverage described in the Employee Medical & Dental Benefits Handbook is provided under a self-funded health Plan. Single employer self-funded plans are not regulated by the Florida Department of Insurance. The payment of claims is completely dependent upon the financial solvency of your Employer, and no guaranty fund exists to cover claims a bankrupt or insolvent employer cannot pay.

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

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

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

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

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

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

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

ADDING NEW DEPENDENTS. Children born to, or placed for adoption with, the Employee during the period of continuation Coverage will be considered qualified beneficiaries and may also receive continuation Coverage provided they are added within the time required by the Plan after the birth or placement for adoption.

If the Employee acquires a new dependent through marriage, birth, adoption, or placement for adoption while the Employee is covered under COBRA, he or she may add that dependent to his or her coverage for the balance of the COBRA coverage period. The Employee must enroll the new dependent within 31 days after the marriage, birth, adoption, or placement for adoption. If COBRA coverage ceases for the Employee before the end of the maximum COBRA coverage period, COBRA coverage also will end for a newly added spouse or dependent child. However,
COBRA CONTINUATION COVERAGE (Continued)

COBRA coverage can continue for a newly added newborn child, adopted child, or child placed with the Employee for adoption until the end of the maximum COBRA coverage period.

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

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

COVERED PERSON’S NOTICE REQUIREMENTS. Under group health plan rules and COBRA law, the Employee, spouse, or other family member has the responsibility to notify the Human Resources Department at:

Halifax Health
303 North Clyde Morris Boulevard
Daytona Beach, FL 32114
386.254.4035

of a divorce, legal separation, or a child losing dependent status under the Plan. To protect your continuation coverage rights in these situations, this notification must be made within 60 days from whichever date is later, the date of the event or the date on which health plan coverage would be lost under the terms of the insurance contract because of the event.

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

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

If this notification is not completed according to the outlined procedures and within the required 60-day notification period, then rights to Continuation Coverage will be forfeited. In addition, keeping an individual covered by the health plan beyond what is allowed by the Plan may be considered insurance fraud on the part of the Employee.

EMPLOYER’S NOTICE REQUIREMENTS. If the qualifying event is a termination of employment, reduction in hours, death, enrollment in Medicare (Part A, Part B, or both) or a commencement of a bankruptcy proceeding, the Employee will notify the Plan Administrator within (1) 30 days of the qualifying event, or (2) 30 days following the date coverage ends.
COBRA CONTINUATION COVERAGE (Continued)

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

The Employee or Dependent must also notify the Plan Administrator of the current address of the individual losing coverage. This is the address where the COBRA notice will be sent. Once it is notified, the Employer will, in turn, notify the eligible COBRA participant that he or she has the right to elect continuation Coverage.

TRADE ADJUSTMENT ASSISTANCE. The Employee may have the right to a second COBRA election period if the Employee was entitled to elect COBRA coverage and did not do so during the original COBRA election period. To qualify, the Employee must be receiving trade adjustment assistance (eligibility requires a government certification under the 1974 Trade Act) and the Employee must have lost his or her coverage under the Plan because of a job loss that resulted in his or her eligibility for trade adjustment assistance. The Employee’s new 60-day COBRA election period will begin the first day of the month in which he or she begins receiving trade adjustment assistance, but it will not extend more than six months after his or her initial loss of group health coverage under the Plan. If the Employee elects COBRA coverage during this second election period and after the end of the initial election period, his or her coverage will begin on the first day of the second election period. The Employee’s coverage will not be retroactive to the date of the initial loss of coverage. The period of time between the Employee’s loss of coverage that resulted in his or her eligibility for trade adjustment assistance and the date he or she began receiving trade adjustment assistance will not be counted in determining whether he or she has a 63-day break in coverage.

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

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

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

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

1. The Social Security Administration must have determined that the qualified beneficiary was disabled according to Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act or at any time during the first 60 days of continuation coverage; and

2. The qualified beneficiary must provide a copy of the determination to their Employer both before the end of the original 18-month period of continuation Coverage and within 60 days of the date of the Social Security disability determination.

Veterans Benefits Improvement Act 2004 (VBIA). This provision is effective for elections made on or after December 10, 2004. Service members and their families are entitled to health coverage under the military health program, TRICARE. USERRA requires that employers offer employees called to active service the right to continue their employer-provided health coverage for themselves and their dependents for a period of up to 24 months.

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

1. The Employer no longer provides group health Coverage for any of its Employees;

2. The appropriate payments for continuation Coverage are not made timely;

3. After the date of the COBRA election, the Employee or Dependent becomes covered under another group health plan that does not contain a pre-existing condition exclusion or limitation which affects them;

4. After the date of the COBRA Election, the Employee or Dependent becomes entitled to Medicare;

5. The Employee or Dependents previously extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;

6. A Participant or their Dependent notifies the Employer they wish to cancel COBRA continuation Coverage; or

7. Any other event that would cause an Employee or Dependent who is not on COBRA to lose coverage under the Plan.
COBRA CONTINUATION COVERAGE (Continued)

Written health evidence is not required to elect continuation Coverage.

Payments for continuation Coverage have to be made within 45 days from the date of election for the initial payment. This initial payment must pay for all months of coverage from the date of the qualifying event up to and including the month in which the payment is made. Continuation Coverage will not become effective until the full and correct payment is made and received. Subsequent payments are due on the first day of each month of Coverage. Premiums are delinquent if not paid 30 days later, in which case Coverage will cease without notice retroactive to the first day of the month. A check that is dishonored for any reason will not be considered payment.

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

VOLUSIA HEALTH NETWORK
Post Office Box 2814
Daytona Beach, FL 32114-2814

Once Coverage under COBRA terminates, no other Coverage is available under this or any other plan offered by Halifax Health.
DENTAL PLAN

There is no dental network - you may use any dentist of your choice!

The design of this dental plan is much simpler than a traditional dental insurance plan. With this Direct Reimbursement Plan, the patient and dentist make all of the decisions on the procedures and costs.

The Dental Plan pays 100% of the first $250 of expenses, regardless of the type of expense (preventive, basic care, major care, orthodontics, etc)*.

After the first $250, the plan will pay 50% of other covered dental expenses up to the annual limit.

Annual Limit – Single  $1,500
Annual Limit – Family $4,200

Dependent Eligibility: Children can be covered through the end of the calendar year in which they turn 26 years of age.

PRE-DETERMINATION OF BENEFITS

Covered Members contemplating dental work are strongly urged to submit a copy of the Treatment Plan to the Claims Administrator. The Treatment Plan should include a list of the services and procedures to be done, the itemized charges for each service and procedure, and the estimated length of treatment.

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

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

Orthodontic Treatment - Total benefits for the course of treatment will then be determined and disbursed as follows:

1. The initial payment will be made when the bands or active appliance is first placed, but will not exceed one-third (1/3) of the total benefit;

2. Further payments will be made on a monthly basis while treatment is continued and the person remains covered by the Plan.

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

This Plan will not pay for:

1. The replacement of a lost or stolen prosthetic device;

2. Charges that are made by someone who is not a Dentist or for treatment not performed by a Dentist. The cleaning and scaling of teeth must be performed by a licensed Dental Hygienist who works under the supervision of a licensed Dentist;

3. Extra sets of dentures or other appliances;

4. Failure to keep an appointment;

5. Completion of any forms;

6. Services for any treatment which is for cosmetic or aesthetic purposes;

7. Charges to the extent that payment under This Plan is prohibited by any law of the jurisdiction in which the Covered Member resides at the time expenses are incurred;

8. Infection control, such as gloves, masks, or any related services;

9. Drugs, home fluoride rinses, toothbrushes and other dental items;

10. Any dental services for which benefits are paid or payable under Workers' Compensation, or any occupational disease, or similar law;

11. Any dental injury sustained due to war, if declared or not;

12. Professional dental services and supplies rendered by the Employee, Employee's spouse, or the children, brother, sisters, parents, or grandparents of either the Employee or the Employee's spouse;

13. Treatment or procedures deemed experimental or investigative by a nationally recognized dental authority such as the American Dental Association. Where conflicting opinions exist, the nationally recognized agencies will take precedence.
DEFINITIONS

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

Accident means any unforeseen and unavoidable event resulting in an Injury.

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

Acute means a condition having rapid onset, severe symptoms and a short course.

Acute Care means health care delivered to patients experiencing acute illness or trauma. Acute Care generally occurs in a Hospital or emergency room setting and is generally a short-term pattern of care in contrast to chronic care, which is long term.

Age Discrimination means a violation of the Social Security Act of 1975, which states that all active Employees and their Covered Dependents age 65 and over are entitled to the same and/or equal benefits they had prior to age 65.

Alcohol or Drug Abuse Treatment Facility means a facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation, and effective treatment of Alcoholism or Drug Dependency. The facility must be supervised by a staff of Physicians and must provide skilled nursing care by licensed Nurses who are directed by a Full-Time R.N. The facility may also be referred to as a Substance Abuse Treatment Facility.

Alcoholism means the chronic and habitual use of alcoholic beverages. This use must: (1) injure the person’s health; (2) interfere with the person’s ability to function normally; or (3) have reached the point where the person has lost his or her self control.

Allowed Amount means the maximum amount on which payment is based for covered health care services.

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

Amendment means a change to the provisions of the Plan and applies to all covered persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.
DEFINITIONS (Continued)

Anesthesia means the administration of a local or general anesthetic agent by a Physician, Anesthetist, Anesthesiologist, or Registered Nurse when rendered in connection with a covered Surgical Procedure. Local - administration of specific anesthetic agent(s) to achieve the loss of pain sensation in a specific location or area of the body. General - administration of specific anesthetic agent(s) to render the patient completely unconscious and without pain sensation.

Appeal means a special kind of complaint made by a member or provider of services upon disagreement with certain kinds of decisions made originally by the Plan. An appeal can be made in the following circumstances: 1) when a request for health care service, supply or prescription, for which an individual is entitled, is not provided under the Plan; 2) when a request for payment for care that is already received is denied by the Plan.

At Work and Work means the time and energy you spend performing, in the customary manner, all of the essential functions of your regular job duties either at one of the Employer’s regular places of business or at some location to which the Employer’s business requires you to travel to perform your regular duties or other duties assigned by your Employer.

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

Balance Billing means when a provider bills you for the difference between the provider’s charge and the allowed amount. A preferred provider may not balance bill you for covered services in excess of the allowed amount.

Bariatric Surgery means an operation on the stomach and/or intestines that helps patients with extreme obesity to lose weight. This surgery is an option for people who cannot lose weight by other means or who suffer from serious health problems related to obesity.

Birthing Center means a facility, which meets the free standing Birthing Center requirements of the State Department of Health in the state where the Covered Person receives the services. A Birthing Center does not mean private offices or clinics of Physicians, or a Hospital or any part of a Hospital which has been designated as a Birthing Center.

Chemical Dependency - see Drug Abuse.

Chemical Dependency Treatment Facility - see Drug Abuse Treatment Facility.

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

Coinsurance means the covered person’s share of the costs of a covered service, calculated as a percentage of the allowed amount for the service. The member pays co-insurance plus any deductibles owed. (For example), if the Plan’s allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven’t met your deductible.

Complications of Pregnancy means a condition or conditions (when the Pregnancy is not terminated) whose diagnosis is distinct from, but caused or affected by Pregnancy. As applied to any Covered Person, the word “Illness” includes Complications of Pregnancy.
DEFINITIONS (Continued)

Complications of Pregnancy include: Acute nephritis or nephrosis; cardiac decomposition; missed abortion; or similar conditions as severe as these. Complications of Pregnancy also include a non-elective Cesarean section, an ectopic Pregnancy which is terminated; and spontaneous termination of Pregnancy which occurs during a period of gestation when a live birth is not possible; pernicious vomiting (hyperemesis gravidarum) and toxemia with convulsions (eclampsia of Pregnancy).

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

Convalescent Care Facility - see Skilled Nursing Facility.

Co-Pay or Co-Payment means the fixed amount payable by the Covered Person at the time of service for certain Covered Services. The amount can vary by the type of covered health care service.

Cosmetic Surgery means a procedure performed primarily to preserve or improve appearance rather than to restore the anatomy, and/or functions of the body which are lost or impaired due to an Illness or Injury. See Covered Medical Expenses on page 12.

Coverage means any covered services or benefits as defined by the Plan.

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

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

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

Day Treatment means care offered by a program accredited by the Joint Commission Accreditation of Healthcare Organizations or in compliance with equivalent standards. Such care must be provided as part of a formal Hospital Outpatient program. Such programs consist of one or more scheduled sessions conducted by members of the Hospital’s staff. The sessions are usually from 4 to 8 hours long. Licensed Drug Abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on Accreditation of Healthcare Organizations or approved by the appropriate state are also considered to be Day Treatment Services.

Deductible means the amount of money the member pays for covered health care services before certain benefits are payable from the Plan. The deductible may not apply to all services.
DEFINITIONS (Continued)

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

**Dependent** means the Covered Employee’s legally married spouse and unmarried children.

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

The term “**children**” means natural children, stepchildren, or children who have been placed under legal guardianship and legally adopted children.

The term “**children**” also means:

- Pre-adopted children (i.e., children placed with a Covered Employee in anticipation of adoption.) Such children will be provided Coverage under the same terms and conditions that apply to Dependents who are a Covered Employee’s natural children, irrespective of whether the adoption has become final, and with no pre-existing conditions limitations applied provided the Dependent is enrolled in a timely manner as stated herein.

- A Covered Person’s child who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to Coverage under the Plan as an “alternate recipient.” The Plan Administrator will communicate the procedures which have been established to determine whether a Medical Child Support Order is qualified under the applicable Florida Statutes, and within a reasonable time after receiving an order will determine whether or not the order is qualified and whether or not the child has been determined to be an “alternate recipient.” The Covered Employee and each child who is the subject of the order will be notified of the determination. Such children may designate a representative to receive copies of all such notices.

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

All children are eligible for coverage through the end of the calendar year in which they turn 26, regardless of whether or not they are married, living at home, in school, or financially dependent upon the covered employee. Dependents of dependents are not covered (per Health Care Reform Act).

**Dependent** children may be eligible for coverage until the end of the calendar year in which they reach the age of 30 provided they meet the following requirements (per Florida State law):

- The child must be a Florida resident or, if not, the child must be a full-time or part-time student whose parent resides in Florida
- The child must not be married
- The child must not have a dependent of his own
- The child must not be covered by another health plan or policy (group or individual) or by Medicare.

The term **Dependent also includes** an Employee’s child while the child is physically or mentally handicapped and is incapable of earning his own living, and who is actually dependent on either parent for maintenance and support, and who is a covered individual on the date immediately preceding the date his health Coverage would have terminated due to age. Proof of incapacity must be submitted to the Administrator within 31 days of the date the child’s health Coverage
DEFINITIONS (Continued)

would have terminated due to age, and thereafter as may be required by the Administrator, but not more frequently than annually following the child’s attainment of the limiting age; otherwise the child’s Coverage will not be continued.

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

No eligible person can be a Covered Employee and a Covered Dependent at the same time.

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

**Drug Abuse** means being physically and/or emotionally Dependent on drugs, narcotics, alcohol or any other addictive substance that results in a chronic disorder affecting, to a debilitating degree, physical health and/or personal or social functioning. The term does not include dependence on tobacco and caffeine.

**Drug Abuse Treatment Facility** means a facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation, and effective treatment of Drug Abuse including Alcoholism. The facility must be supervised by a staff of Physicians and must provide Skilled Nursing Care by licensed Nurses who are directed by a Full-Time R.N.

**Drug Dependency** - see Drug Abuse.

**Drug Dependency Treatment Facility** - see Drug Abuse Treatment Facility.

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

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

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

**Eligibility Waiting Period** means the time beginning with the Employee’s most recent date of continuous employment with the Employer, and ending on the date he is eligible for Coverage under This Plan.

**Employee** means a person who is directly employed in the regular business of and compensated for services by the Employer or any subsidiary or affiliate, and who actively expends time and energy in the service of the Employer at the Employer’s usual place of business or some other location which is usual for the Employee’s particular duties, other than the Employee’s home. An Employee will include consultants and terminated Employees with a severance agreement requiring continuation of benefits.
DEFINITIONS (Continued)

**Employer** means the Plan Administrator. It also includes any of the affiliates or subsidiaries that are listed in the Plan Document. The Plan Administrator will act on behalf of these affiliates and subsidiaries.

**Enrollment Period** means the month as designated by the Plan in which an Employee may change his election. These changes, if not originally requested within 31 days of a Change in Status, will be subject to the Late Applicant’s provision.

**Excluded Services** means health care services that your plan does not pay for or cover.

**Exclusive Provider Organization (EPO)** means a network or group of health care providers who have entered into an agreement with your Employer to provide services at a pre-determined rate.

**EPO Physician or Provider** - a Physician or other health care provider, such as a Hospital, a clinic, or a Pharmacy, who has chosen to participate in the EPO and has agreed to accept the pre-determined payment and bill you only for the Co-Payment, Deductible, and non-Covered Services.

**Non-EPO Physician or Provider** - a Physician or other health care provider, such as a Hospital, a clinic, or a Pharmacy, who has chosen not to participate in the EPO. Since participation arrangements have not been established with these Physicians or other providers, the member will be responsible 100% of billed charges. There is no coverage for out-of-network medical care.

**Experimental** means treatment, procedure, drug, device, or technology as to which the Plan Administrator or its designee has determined that any of the following applies (at the time it makes a determination regarding Coverage):

1. It cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not been given at the time of treatment, procedure, drug, or device is furnished; or

2. It is subject to review and approval by the treating facility’s institutional review board, or other institutional review board; or

3. Reliable Evidence shows that to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis for the condition in question: A) It is undergoing phase, I, II, or III clinical trials (as defined by FDA regulations, regardless of whether the trial is subject to FDA oversight), or is under study; or B) Further clinical trials or studies are needed according to the experts’ consensus opinion. “Reliable Evidence” means published reports and articles in authoritative medical and scientific literature; or the written protocol or protocols used by the treating facility, or by another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility, or by another facility studying substantially the same drug, device, medical treatment or procedure. In determining whether benefits should be excluded, the prevailing criteria for consideration will be whether the service is recognized as standard medical care for the condition, disease, illness or injury being treated;

**Extended Care Facility** - see Skilled Nursing Facility.
DEFINITIONS (Continued)

**Grievance** means a written, or in the case of a specific time-sensitive issue, a verbal expression of dissatisfaction or complaint. The member, the member’s authorized representative, a provider authorized to act on the member’s behalf, or a state agency may submit a grievance (see “Claim Denial and How to Appeal a Denial of Benefits” section).

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

**Home Health Care Agency** means a public or private agency or organization, licensed and operated according to the law that specializes in providing medical care and treatment in the home. The agency must have policies established by a professional group and at least one Physician and one registered graduate Nurse to supervise the services provided.

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

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

The facility must have an interdisciplinary medical team consisting of at least one Physician, one registered Nurse, one social worker, one volunteer and volunteer program. A Hospice facility is not a facility or part thereof which is primarily a place for rest, Custodial Care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

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

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

**Injury** means a condition which results independently of an Illness and all other causes and is a result of an externally violent force or Accident.

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

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

**Investigative** means techniques which have progressed to limited human application, but lack wide recognition as proven and effective procedures in clinical medicine or Surgery.

**Late Applicant/Entrant** means an Employee or Dependent who does not enroll when first eligible to enroll, or during the time specified during the Special Enrollment when there is a Change in Status or loss of Coverage under another plan.

**Layoff** means that the Employer ceases to employ the Employee, but expects to recall the Employee to Full-Time Active Work after a limited period of time.

**Leave of Absence** means a period of time, of stated duration, during which the Employee does not work but after which time the Employee is expected to return to Active Full-Time Work.

**Mammography** means the x-ray examination of the breast using equipment dedicated specifically for Mammography.

**Medicaid** means the state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

**Medical Emergency** means an Illness and/or Injury which occurs suddenly and unexpectedly with acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention or use of the most accessible Hospital equipped to furnish care could reasonably be expected to result in the death or serious impairment of the Covered Person’s health or bodily functions.

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

**Medically Necessary or Medical Necessity** means a specific medical, health care, or Hospital service that is required for the identification, treatment, or management of a medical symptom or Condition. A service, care or supply is Medically Necessary if it is: 1) consistent with the symptom, diagnosis, and treatment of the Condition; and 2) in accordance with standards of good medical practice; and 3) approved by the appropriate medical body or board for the Condition in question; and 4) is not primarily for the convenience of the Covered Person, a Physician, or other Provider; and 5) is the most appropriate, efficient, and economical medical supply, service or level of care which can be safely provided.

**Medicare** means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

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

**Mental/Nervous Treatment Facility** means a facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation, and effective treatment of Mental/Nervous Disorders; infirmary-level medical services; supervision by a staff of
DEFINITIONS (Continued)

Physicians; and skilled nursing care by Licensed Practical Nurses who are directed by a Full-Time R.N. The facility must also prepare and maintain a written Plan of treatment for each patient. The Plan must be based on medical, psychological and social needs.

Network means the facilities, providers and suppliers the plan has contracted with to provide health care services.

Network Fee Schedule means a schedule of maximum charges for contractual providers who charge on a fee for service basis. The fee is based on the current Medicare fee schedule and a network provider contractual percentage. The physician also agrees to accept as payment in full. Also known as a fee allowance, fee maximum or capped fee.

Newborn Care means the charges made by a Hospital for routine nursery care, the attending pediatrician’s charges for the care of a newborn child, and the Physician’s charge for circumcision.

Non-EPO Physician or Provider means a Physician or other health care provider, such as a Hospital, a clinic, or a Pharmacy, who has chosen not to participate in the EPO. If you receive services in a Non-EPO Hospital you will be responsible for 100% of billed charges. There is no coverage for out-of-network medical care.

Non-Therapeutic Abortion means an elective termination of Pregnancy not caused by medical reasons. The Pregnancy must be terminated before a live birth is possible. It does not mean a miscarriage.

Normal Pregnancy; Pregnancy does not include any Complications of Pregnancy.

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

Nurse Midwife or Certified Nurse Midwife means a person who has been certified as a Nurse Midwife by the American College of Nurse-Midwives and who is authorized to practice as a Nurse Midwife under the state regulations where the Covered Person receives the services.

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

Open Enrollment/Annual Enrollment Period/Choice Period means, the only period of time (usually, but not always, a one-month period each year) in which an Employee can enroll for Coverage, drop Coverage, or make any changes (unless there is a Status Change or Special Enrollment).

Out-of-Area means outside of the network geographical Service Area.

Out-of-Pocket Limit means the most you pay during a policy period (usually a year) before the plan begins to pay 100% of the allowed amount. This limit does not include premiums, balance-billed charges, penalties for failure to obtain pre-cert for services, or non-network provider charges.
DEFINITIONS (Continued)

**Outpatient** means a person who receives care for a Sickness or an Injury but who is not confined as an Inpatient and is not charged for room and board.

**Palliative** - an alleviating measure. To relieve, but not cure.

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

**Participating Provider Network** means the group of health care providers who has an agreement with your Employer to provide services through a EPO (Exclusive Provider Organization).

**Period of Confinement** means that a Covered Person is discharged from a Convalescent/Skilled Nursing/Extended Care Facility and again becomes an Inpatient in such facility due to the same or related causes separated by less than 3 months in a row. In regards to Hospital stays, a Covered Person is discharged from the Hospital and again becomes an Inpatient in such facility due to the same or related cases and had not, with respect to a Covered Employee, returned to Active Work for at least one full day; or with respect to a Dependent, was not separated by a period of complete recovery.

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

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

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

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

**Physician/Doctor** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Optometrist (O.D.), Licensed Professional Physical Therapist, Physiotherapist, Licensed Professional Counselor, Psychiatrist, Audiologist, Speech Language Pathologist, Midwife and any other Practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan; This Plan** whenever used herein without qualification will mean the Plan of benefits as contained in this Employee Medical & Dental Benefits Handbook and any agreements, schedules and Amendments endorsed by the Employer.

**Plan Administrator** means the person or organization responsible for the day-to-day functions and management of This Plan.

**Podiatry** means the diagnosis, treatment, and prevention of the conditions of the feet.
DEFINITIONS (Continued)

**Practitioner** means a person who is a licensed Practitioner of the healing arts who is regulated by a state or federal agency and is acting within the scope of his or her license.

**Premature Birth** means a birth occurring at 37 weeks or less before full term.

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

**Prescription Drug Coverage** means the Plan that helps pay for prescription drugs and medications.

**Prescription Drug Plan** means an arrangement made by an Employer with a Preferred Prescription Drug Provider (either a drug company or a specific Pharmacy or group of pharmacies) who have contracted with the Plan, to fill Prescriptions for individuals Covered under the Plan. The preferred Prescription provider agrees to accept only a percentage of the full cost of the Prescription from the Covered Person at the time the Prescription is filled, and bill the Plan for the balance of the cost of the Prescription.

**Provider** means a physician, health care professional or health care facility licensed, certified or accredited as required by state law.

**Psychiatric Disorder** means neurosis, psychoneurosis, psychopathy or psychosis.

**Psychiatric Treatment Program** means licensed Psychiatric Treatment Programs. These programs must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or be in compliance with equivalent standards or be approved in the state where the program is run.

**Rehabilitation Facility** means a public or private facility, licensed and operated according to the law, which maintains permanent and Full-Time facilities to mainly provide Rehabilitative Services to correct functional defects which remain after a catastrophic Illness, crippling Injury, or Acute trauma.

**Rehabilitative Services** means the health care services rendered to correct functional defects which remain after a catastrophic Illness, crippling Injury, or Acute trauma.

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

**Screening Colonoscopy** is covered every 10 years at a Contracted Network Provider (i.e. Halifax Medical Center) at 100% of the maximum VHN plan allowable not subject to deductible or copay. Guidelines recommend that screening exams be performed once every ten years.
DEFINITIONS (Continued)

starting at age 50. This benefit is available to all members that meet these guidelines. This procedure requires Pre-Certification prior to the procedure being done and must be billed by the provider as a screening colonoscopy.

Service Area means the geographical area within which the EPO’s Covered Services are available.

Short Term Rehabilitation means Rehabilitative Services received on a limited basis.

Sickness means Illness or disease. It includes Pregnancy and the resulting childbirth, miscarriage, abortion, and any Complications of Pregnancy. For newborn children, the term includes: medically diagnosed congenital defects; birth abnormalities; or Premature Birth. Whether or not a birth is premature must be determined by a Physician.

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

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

Smoking Cessation means the process of discontinuing tobacco smoking. Tobacco contains nicotine, which is addictive, making the process of quitting often very prolonged and difficult.

Special Charges means the charges made by a Hospital or a Convalescent Facility on its own behalf for the services and supplies that are required for the care and treatment of a Sickness or an Injury. It does not mean fees for professional services or the charges that are made for room, meals, and personal items.

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

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

Status Change means, a life event which qualifies an Employee to make a change in his Coverage, outside of the “Open Enrollment Period” or “Annual Enrollment Period”.

Substance Abuse - see Drug Abuse.

Substance Abuse Treatment Facility - see Alcohol or Drug Dependency Treatment Facility.

Surgery or Surgical Procedure means any of the following procedures (excluding oral Surgical Procedures):
1. Incision, excision or electrocauterization of any organ or body part;
2. Reconstruction of any organ or body part or the suture repair of lacerations;
DEFINITIONS (Continued)

3. Reduction of a fracture or dislocation by manipulation;
4. Use of endoscopic procedure to explore for removal of a foreign body or tissue from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder or ureter;
5. Puncture for aspiration;
6. Injection for contrast media testing; or

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

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

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

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

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

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

**Terminally Ill Person** means a covered individual whose life expectancy is 6 months or less as certified by a Physician.

**Total Disability (Totally Disabled)** means, in regard to a Covered Employee, the complete inability to regularly perform all the essential functions of the person’s occupation with the Employer as the result of a non-occupational Illness or Injury. For Covered Dependents, Total Disability means the inability to continuously perform the normal duties of a person of the same age, sex and in good health.

**Uniformed Services** means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

**Weekend Non-Emergency Hospital Admission** means an Admission to a Hospital on a Friday, Saturday or Sunday at the convenience of the Covered Person or his or her Physician when there is no cause for an emergency Admission and the Covered Person receives no surgery or therapeutic treatment until the following Monday or later.

**Weight Management** means a long-term approach to a healthy lifestyle which includes a balance of healthy eating and physical exercise to equate energy expenditure and energy intake. It is also the development healthy eating habits while using tips and useful tools.
COVERED PREVENTIVE HEALTH SERVICES FOR ADULTS

Abdominal Aortic Aneurysm one-time screening for men of specified ages 65-75 who have ever smoked at least 100 cigarettes in their lifetime.

Alcohol Misuse screening and counseling

Aspirin Use to prevent cardiovascular disease for men and women of certain ages

Blood Pressure screening for all adults

Cholesterol screening for adults of certain ages or at higher risk

Colorectal Screening for adults over 50

Depression screening for adults

Diabetes (Type 2) screening for adults with high blood pressure

Diet counseling for adults at higher risk for chronic disease

HIV screening for all adults at higher risk

Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  o Hepatitis A
  o Hepatitis B
  o Herpes Zoster
  o Human Papillomavirus
  o Influenza (Flu Shot)
  o Measles, Mumps, Rubella
  o Meningococcal
  o Pneumococcal
  o Tetanus, Diphtheria, Pertussis
  o Varicella

Obesity screening and counseling for all adults

Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk

Syphilis screening for all adults at higher risk

Tobacco Use screening for all adults and cessation interventions for tobacco users
COVERED PREVENTIVE SERVICES FOR WOMEN  
(INCLUDING PREGNANT WOMEN)

The eight new prevention-related health services marked with an asterisk (* ) must be covered with no cost-sharing in plan years starting on or after August 1, 2012.

Anemia screening on a routine basis for pregnant women

Bacteriuria urinary tract or other infection screening for pregnant women

BRCA counseling about genetic testing for women at higher risk

Breast Cancer Mammography screenings every 1 to 2 years for women over 40*

*On January 12, 2016, the U.S. Preventive Services Task Force (USPSTF) published a final set of recommendations on screening for breast cancer in women. The following summarizes those recommendations:

• Ages 40-49 – A woman should make an informed, individualized decision based on the woman’s values, preferences, and health history;

• Ages 50-74 – A woman should have a mammography every two years;

• Ages 75 and older – More research is needed, because current science is inadequate to recommend for or against a woman in that age range obtaining a mammography.

The USPSTF report & related document can be found at www.uspreventiveservicestaskforce.org

Breast Cancer Chemoprevention counseling for women at higher risk

Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women*

Cervical Cancer screening for sexually active women

Chlamydia Infection screening for younger women and other women at higher risk

Contraception Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs*

Domestic and interpersonal violence screening and counseling for all women*

Folic Acid supplements for women who may become pregnant

Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes*

Gonorrhea screening for all women at higher risk

Hepatitis B screening for pregnant women at their first prenatal visit

Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women*
Human Papillomavirus (HPV) DNA Test  high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older*

Osteoporosis  screening for women over age 50 depending on risk factors

RH Incompatibility  screening for all pregnant women and follow-up testing for women at higher risk

Sexually Transmitted Infections (STI)  counseling for sexually active women*

Syphilis  screening for all pregnant women or other women at increased risk

Tobacco Use  screening and interventions for all women, and expanded counseling for pregnant tobacco users

Well-woman visits  to obtain recommended preventive services*

**COVERED PREVENTIVE SERVICES FOR CHILDREN**

Alcohol and Drug Use  assessments for adolescents

Autism  screening for children at 18 and 24 months

Behavioral Assessments  for children of all ages

Blood Pressure  screening for children

Cervical Dysplasia  screening for sexually active females

Congenital Hypothyroidism  screening for newborns

Depression  screening for adolescents

Developmental Screening  for children under age 3, and surveillance throughout childhood

Dyslipidemia  screening for children at higher risk of lipid disorders

Fluoride Chemoprevention  supplements for children without fluoride in their water source

Gonorrhea  preventive medication for the eyes of all newborns

Hearing  screening for all newborns

Height, Weight and Body Mass Index  measurements for children

Hematocrit or Hemoglobin  screening for children

Hemoglobinopathies  or sickle cell screening for newborns

HIV Screening  for adolescents at higher risk
**Immunization** vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:

- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type b
- Hepatitis A
- Hepatitis B
- Human Papillomavirus
- Inactivated Poliovirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

**Iron** supplements for children ages 6 to 12 months at risk for anemia

**Lead** screening for children at risk of exposure

**Medical History** for all children throughout development

**Obesity** screening and counseling

**Oral Health** risk assessment for young children

**Phenylketonuria (PKU)** screening for this genetic disorder in newborns

**Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk

**Tuberculin** testing for children at higher risk of tuberculosis

**Vision** screening for all children
FORMS

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)…………..a
ACCIDENT DATE AND DETAILSD...............................................b-e
CLAIM FORM............................................................................f
MEDICAL NUTRITION THERAPY................................................g
STAT DOCS..............................................................................h
MEDICARE DRUG STATEMENT..................................................i-k
HIPAA PRIVACY STATEMENT....................................................l-n
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION.....o
WEIGHT MANAGEMENT...............................................................p
BARIATRIC SURGERY.................................................................p-q
SMOKING CESSATION...............................................................r
ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

If your physician is using a lab, pathologist, or procedure that is not covered by the Plan, the physician is required to present you with an Advance Beneficiary Notice of Non-Coverage (ABN). This form (shown below) will show the estimated cost of the test(s) and give you the option to either have the procedure done (understanding that you are responsible for 100% of the charges) or not to have the procedure done.

Notifier(s)
Patient Name: Identification Number:

<table>
<thead>
<tr>
<th>Listed or Checked Items Only:</th>
<th>Reason VHN May Not Pay:</th>
<th>Estimated Cost:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not a covered benefit or provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td>not contracted with VHN</td>
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</tr>
</tbody>
</table>

WHAT YOU NEED TO DO NOW:
• Read this notice, so you can make an informed decision about your care.
• Ask us any questions that you may have after you finish reading.
• Choose an option below about whether to receive the checked items listed in the first box above.

Options: Check only one box. We cannot choose a box for you.

Option 1. I want the procedure listed above. I understand that I am responsible for payment and I am expected to pay in advance.

Option 2. I don’t want the procedure listed above. I understand with this choice I am not responsible for payment. I also understand the medical risks that may be associated with not having this procedure done.

Additional Information:

Signature: Date:
Accident Questionnaire

Date:______________ VHN Subscriber #: _____________________________

Subscriber Name:_____________________ Phone:__________________

Address: __________________________________________________________________________

City/State/Zip:________________________ Date of Birth:____________

Email Address: ______________________________________________________________________

Date of Service:_________________ Provider:____________________

Section 1

1. Date of accident or injury:________________________________________

2. Type of Accident (Please check):
   - Work (Complete section 2)
   - Automobile (Complete section 3)
   - Motorcycle (Complete section 3)
   - Other accident (Complete section 4)

3. Have you hired an attorney as a result of this accident?
   - Yes
   - No

4. Name, address, and phone number of your attorney (if applicable):
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
Accident Questionnaire (continued)

Section 2

Complete the following questions if this accident or injury is work related.

1. Have you filed a worker’s compensation claim?
   - Yes
   - No

2. Has your employer or their worker’s compensation insurance company accepted liability?
   - Yes
   - No
   - Pending

3. Worker’s compensation insurance company:
   - Case workers name: _________________________________
   - Phone number: _________________________________
   - Claim number: _________________________________

Section 3

Complete the following questions if this accident or injury is related to an automobile accident or motorcycle accident.

1. Was the patient:
   - Driver
   - Passenger
   - Pedestrian
   - Other (Please explain and give specific information)

   ____________________________________________________
   ____________________________________________________
   ____________________________________________________
   ____________________________________________________

2. Did another person cause the accident?
   - Yes
   - No
Accident Questionnaire (continued)

3. Responsible party’s Name:__________________________
   Address: ______________________________
   Phone Number: __________________________

4. Responsible party’s Insurance Company (including No-Fault Ins.):
   Name:_________________________________
   Address: ______________________________
   Phone Number: __________________________
   Policy number: __________________________

Section 4

Complete the following questions if this accident or injury is related to an “other” accident.

1. Specific location of accident (Name and Address):
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

2. Please describe in detail how the accident occurred:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

3. Did another person cause this accident?
   ☐ Yes
   ☐ No
Accident Questionnaire (continued)

4. Responsible party’s Name:_____________________________________
   Address: ______________________________________
   Phone Number: ____________________________________

5. Responsible party’s Insurance Company (including No-Fault Ins.):
   Name: _______________________________________
   Address: ______________________________________
   Phone Number: __________________________
   Policy number: __________________________

I certify to the best of my ability and knowledge that the above
information is true and correct.

   Print Name: _______________________________________
   Signature: _______________________________________
   Date: ____________________________________________

Please forward this questionnaire to:

Volusia Health Network
P.O. Box 2814
Daytona Beach, FL. 32120
Att: Claims Department
CLAIM FORM

Please forward to: Volusia Health Network, P.O. Box 2814, Daytona Beach, FL 32120
Phone: 386-425-4846, option 1.

LIST ALL COVERED DEPENDENTS ON THIS FORM – AN UPDATED CLAIM FORM IS REQUIRED ANNUALLY.

Section 1 – SUBSCRIBER INFORMATION

<table>
<thead>
<tr>
<th>Subscriber’s Name</th>
<th>Volusia Health Network ID #</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address</td>
<td>City</td>
<td>State</td>
</tr>
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<td></td>
<td></td>
<td>Zip Code</td>
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</tbody>
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Subscriber’s Email Address (not halifax.org)

Are you currently working for another employer?  □ No  □ Yes – If yes, name of other employer:

If Retiree: Are you currently working at Halifax Health?  □ No  □ Yes

Employer:  □ Halifax Health  □ Other:

Is Subscriber covered by any other insurance (other than Volusia Health Network)? Please attach a copy of insurance card.
□ No – Go to Section 2  □ Yes – Other Health Insurance – complete Section A below

Section A: Name of Other Health Insurance Carrier

<table>
<thead>
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<th>Effective Date</th>
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<table>
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<tr>
<th>Name of Policy Holder (person who has the policy)</th>
<th>Policy Holder’s Social Security #</th>
<th>Policy Holder Date of Birth</th>
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</thead>
</table>

Section 2 – DEPENDENT INFORMATION (if covered on subscriber’s policy)

<table>
<thead>
<tr>
<th>Relationship</th>
<th>First Name</th>
<th>Last Name</th>
<th>Birth Date</th>
<th>Covered by other insurance?</th>
<th>Effective Date – Other Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse: Is spouse disabled?</td>
<td></td>
<td></td>
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<td>(attach copy of card)</td>
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<td>□ No  □ Yes</td>
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<td>If yes, name of carrier:</td>
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<td>Child: Is child subject to divorce decree?</td>
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<td>□ No  □ Yes</td>
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*Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree." Florida Statutes, Section 617. 234

Subscriber Certification: I certify that all information provided on this form and on the attached itemized statements are true and correct to the best of my knowledge. I authorize any doctor, hospital, other provider of care or supplies, employer, labor union, or insurance company to furnish Volusia Health Network or its representatives any information required to process this claim. A photocopy of this should be honored.

Subscriber Signature: X Date

**** Please complete and return this form as soon as possible. Failure to do so could delay payment of your claims. **** N-HMC - 454 – 10/15
Medical Nutrition Therapy

Attention: Volusia Health Network (VHN) members at Halifax Health

VHN is offering a wonderful benefit to members. Meet with our registered and licensed Dietitians for two sixty minute appointments a year, only a $30/co-pay ($294.00 value)

Who can benefit? YOU! (Check any that apply.)

___ Do YOU have a family history of diabetes? YOU want to keep diabetes at bay. A dietitian can teach YOU skills to aid your efforts in preventing diabetes.

___ Do YOU want improved heart health? Meet with a dietitian to learn ways you can modify your diet to lower cholesterol/triglycerides and blood pressure?

___ Are YOU trying to lose weight?

___ Maybe YOU want to eat healthy and stick to a budget?

___ Are YOU crazy busy with no time to cook? We can help with meal planning tips.

___ Pregnant/Breastfeeding moms: we can provide guidance and assurance that YOU are eating healthy to support your baby’s growth and development.

___ Athletes, YOU are working hard to get fit for your next event. We can help you fine tune your diet for top performance.

___ Are YOU quitting smoking and don’t want to gain weight?

___ Do YOU have food allergies or food sensitivities and wonder what is safe to eat?

What is the benefit?

A Registered dietitian provides medical nutrition therapy for health conditions, monitors health parameters, serves as a health coach, and helps YOU achieve a better quality of health through improved eating habits.

If you want to become more engaged and in control of your health, take a closer look at your diet with a dietitian who can help YOU achieve your health goals!

Schedule an appointment with a Halifax Health – Wellness Center Dietitian for a nutrition assessment, education/coaching and recommendations tailored to your needs
Teladoc® gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone or video consults. It's an affordable alternative to costly urgent care and ER visits when you need care now.

**WHEN CAN I USE TELADOC?**
Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care.
- When you need care now
- If you’re considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

**GET THE CARE YOU NEED**
Teladoc doctors can treat many medical conditions, including:
- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

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Important Notice from Halifax Health About Your Prescription Drug Coverage and Medicare

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

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

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

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your Halifax Health Employee EPO Health Plan coverage will not be affected. If you or your dependent are eligible for Medicare, you may wish to consider a Medicare Advantage prescription drug plan. For more information, contact our Enrollment Department at 386-425-4846, option 4.

If you or a dependent decide to join a Medicare drug plan and drop your current Halifax Health Employee Health Plan coverage, be aware that you and your dependents will not be able to get this coverage back.
Important Notice from Halifax Health About
Your Prescription Drug Coverage and Medicare (continued)

For Retirees with Medicare…

Effective January 1, 2006 Halifax Health Retirees have the following options available:

* You may remain on the Halifax Health Employee EPO Health Plan medical and prescription drug plan instead of enrolling in Medicare D. If you select this option, you will continue to receive the same benefits at the same cost for the remainder of this plan year. Your coverage under Halifax Health Employee EPO Health Plan is creditable coverage, so you will not be subject to any penalties or additional costs for Medicare D if you decide to enroll at a later date.

OR

* You may terminate your medical and prescription drug coverage with Halifax Health Employee EPO Health Plan and enroll in Medicare D. If you select this option, you will have only the benefits offered by Medicare. Once you terminate your retiree coverage with Halifax Health Employee EPO Health Plan, you will not be eligible to enroll in the plan at a later date. If you select this option, you may also wish to enroll in a Medicare Supplement or Medigap policy to cover your out-of-pocket expenses for hospital and doctor visits.

OR

* You may remain on the Halifax Health Employee EPO Health Plan medical and prescription drug plan, and also enroll in Medicare D. If you select this option, you will still have the same benefits for hospital and doctor visits as you do today, but you will only be able to file your prescription drug claims under Medicare D. For retirees, Medicare will be the primary payer; however the Halifax Health Employee EPO Health Plan prescription drug plan does not coordinate benefits with Medicare or other payers. This option would primarily be attractive to those retirees that are eligible for the low-income subsidy for Medicare D, which may provide richer benefits than the Halifax Health Employee EPO Health Plan.

For Active Employees with Medicare…

When you are an active employee, generally the Halifax Health Employee EPO Health Plan will be the primary coverage for you and any dependent(s) that you cover, even if you or your dependent also has Medicare.

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

You should also know that if you drop or lose your coverage with Halifax Health Employee EPO Health Plan and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month.

Important Notice from Halifax Health About
Your Prescription Drug Coverage and Medicare (continued)

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

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

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

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date: 11/17/2014  
Name of Entity/Sender: Halifax Health Employee EPO Health Plan  
Contact--Position/Office: Enrollment Department – Volusia Health Network  
Address: P.O. Box 2814, Daytona Beach, FL, 32120  
Phone Number: 386-425-4846, option 4

CMS Form 10182-CC

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

Group Health Plan’s Designation of Entity to Act on its Behalf.
The Halifax Health Plan (the Plan) has determined that it is a Group Health Plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the Plan Sponsor, Halifax Health to take all actions required to be taken by the Group Health Plan in connection with the HIPAA Privacy Rule.

Group Health Plan’s Disclosure of Protected Health Information (PHI) to the Plan Sponsor – Required Certification of Compliance by Plan Sponsor.
Except as provided below with respect to the Group Health Plan’s disclosure of summary health information, the Group Health Plan will (a) disclose PHI to the Plan Sponsor or (b) provide for or permit the disclosure of PHI to the Plan Sponsor by a health insurance issuer, only if the Group Health Plan has received a certification (signed on behalf of the Plan Sponsor) that:
1. the Employee Medical & Dental Benefits Handbook establishes the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the Privacy Rule provisions;
2. the Employee Medical & Dental Benefits Handbook incorporates the Plan provisions; and
3. the Plan Sponsor agrees to comply with the Plan provisions.

Permitted Disclosure of Individuals’ Protected Health Information (PHI) to the Plan Sponsor.
1. The Group Health Plan (and any Business Associate acting on behalf of the Group Health Plan), or any health insurance issuer servicing the Group Health Plan will disclose individuals’ PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administrative functions. Such disclosure will be consistent with the Privacy Rule provisions.
2. All disclosures of the PHI of the Group Health Plan’s individuals by the Group Health Plan’s Business Associate or health insurance issuer to the Plan Sponsor will comply with the restrictions and requirements set forth in the Privacy Rule provisions.
3. The Group Health Plan (and any Business Associate acting on behalf of the Group Health Plan), may not, and may not permit a health insurance issuer, to disclose individuals’ PHI to the Plan Sponsor for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
4. The Plan Sponsor will not use or further disclose individuals’ PHI other than as described in the Employee Medical & Dental Benefits Handbook and permitted by the Privacy Rule provisions.
5. The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals’ PHI received from the Group Health Plan (or from the Group Health Plan’s health insurance issuer), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
6. The Plan Sponsor will not use or disclose individuals’ PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
7. The Plan Sponsor will report to the Group Health Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Employee Medical & Dental Benefits Handbook and in the Privacy Rule provisions, of which the Plan Sponsor becomes aware.
Disclosure of Individuals’ Protected Health Information (PHI) – Disclosure by the Plan Sponsor.

1. The Plan Sponsor will make the PHI of the individual who is the subject of the PHI available to such individual in accordance with 45 C.F.R. § 164.524.

2. The Plan Sponsor will make individuals’ PHI available for amendment and incorporate any amendments to individuals’ PHI in accordance with 45 C.F.R. § 164.526.

3. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals’ PHI that it must account for in accordance with 45 C.F.R. § 164.528.

4. The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals’ PHI received from the Group Health Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Group Health Plan with the HIPAA Privacy Rule.

5. The Plan Sponsor will, if feasible, return or destroy all individuals’ PHI received from the Group Health Plan (or a health insurance issuer with respect to the Group Health Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use and disclosure was made. Additionally, the Plan Sponsor will not retain copies of such PHI after such information is no longer needed for the purpose for which the use and disclosure was made. If however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

6. The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.

7. The Plan Sponsor will ensure that the adequate separation that is required by 45 C.F.R. § 164.5504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures.

8. Plan Sponsor will insure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information.

9. Plan Sponsor will report to the Plan any security incidents of which it becomes aware.

10. The Plan Sponsor will ensure that the required adequate separation, described below, is established and maintained.

Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor.

1. The Group Health Plan, or health insurance issuer with respect to the Group Health Plan, may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of:
   a. Obtaining premium bids from health plans for providing health insurance coverage under the Group Health Plan; or
   b. Modifying, amending, or terminating the Group Health Plan.
2. The Group Health Plan, or a health insurance issuer with respect to the Group Health Plan, may disclose enrollment and disenrollment information to the Plan Sponsor as provided for in the HIPAA Privacy Rule.

Required separation between the Group Health Plan and the Plan Sponsor.

1. In accordance with the HIPAA Privacy Rule, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to individuals’ PHI received from the Group Health Plan or from a health insurance issuer servicing the Group Health Plan.

2. This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive individuals’ PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Group Health Plan. These individuals will have access to individuals’ PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals’ PHI in violation of, or noncompliance with, these provisions.

3. The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Group Health Plan and will cooperate with the Group Health Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Many of our patients allow family members and/or legal designee such as their spouse, parents or others to call and request medical, dental or claim information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient’s consent. If you wish to have your medical, dental or claim information released to family members and/or legal designee, you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Volusia Health Network to release my medical, dental and/or claim information to the following individual(s).

1. ___________________________  Relation to Patient: ___________________
2. ___________________________  Relation to Patient: ___________________
3. ___________________________  Relation to Patient: ___________________

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

This authorization will be in effect for the duration listed below:

Beginning Date: _____/_____/______          Ending Date: _____/_____/______

Signature: ___________________________  Date: ______________
WEIGHT MANAGEMENT (LIGHTER LIFESTYLES) QUALIFICATIONS

Halifax Health’s Weight Management (Lighter Lifestyles) Program is available to VHN members who meet the following criteria:

* Member must have a BMI 30.0 or higher
* Member is responsible for a $200 buy-in. This fee can be paid up front or in (4) $50.00 monthly installments. Payments may be made by payroll deduction, cash, credit card or check.

What is included in the $200 buy-in?

1. Member will have the option of attending one of the five weight loss programs. These programs range from the least intense to the most intense weight loss plans. Classes are held Monday through Thursday evening at 5:00pm, and Thursday afternoon at 2:00pm. Classes are led by a registered dietician. Members are weighed at class time and receive blood pressure checks, blood pressure checks, labs and physician consult.

2. Member receives access to the Wellness Center. This membership includes a fitness evaluation, exercise prescription and orientation to the appropriate equipment.

3. If the member meets weight loss goal in a period of six months, they can be recertified for an additional six months.

4. Meal replacement supplements are not included.

Please call 386.254.4031 for more information or to schedule a free orientation with one of our dieticians.

BARIATRIC SURGERY QUALIFICATIONS

East Coast Bariatrics is the network provider for Volusia Health Network. At this time only the Roux-en-Y and Gastric Sleeve are covered by the Self-Funded Program. Medical necessity must be determined by VHN’s Medical Directors. Medical necessity is defined as:

1. Upon entering the program, have a BMI greater than or equal to 40. Or BMI greater than 35 and 2 co-morbidities such as sleep apnea, diabetes, cardiac and respiratory diseases. AND
2. Provide at least 3 years of clinical documentation documenting obesity as a long term condition. AND
3. Active participation in the Halifax Lighter Lifestyles Program to include documented attendance of 24 weeks of the program and documentation of actively following program guidelines. AND
4. Actively work out in the Halifax Health Fitness Center at least twice weekly or at a legitimate credentialed facility* during attendance of the required length of the Halifax Health Lighter Lifestyles Program. AND
5. Being identified as an appropriate surgical candidate by East Coast Bariatrics Team consisting of: Bariatric Surgeons, PCP/IM Physicians, Psychiatrists/ Psychologist, Registered Dietitians/Exercise Physiologists. AND
6. Being willing and able, including financial and medical responsibilities, to participate in the pre-op and post-op program. AND
7. Meet the requirements of Interqual Criteria.

*Any variation from the Halifax Health Fitness Center MUST be approved. If approval is
granted, monthly log documentation MUST be submitted from the facility’s system with
appropriate number of program required visits AND a weekly workout plan to show activities
performed during those visits. AND the member is responsible for any and all membership fees
associated with said facilities that are not reimbursable by the Plan.

Indications for Obesity Surgery
Eligible candidates for Bariatric surgery must meet the following criteria:

1. You must have a Body Mass Index (BMI) of 40 or greater.
2. If your BMI is between 35-40, then you must have at least two significant co-morbidities
   (see above)
3. You must be age eighteen or older.
4. You must not have any Psychiatric or medical problems that would make surgery
   unnecessarily risky.
5. You should not be drug or alcohol dependent, and if you have a history of such, you must
   be well into a qualified treatment program for at least one year.
6. If you smoke, you must stop.
7. You must have a personal ongoing commitment to follow the nutritional, exercise,
   medication and laboratory protocols indicated by the program.
8. You must agree to random screening for compliance in items 5 and 6 related to any
   chemical dependency at your own expense.
9. You must have a personal commitment to attend the program support group meeting on a
   regular basis.
10. You must make a personal ongoing commitment to return to the program for necessary
    follow-up appointments.

Note: Member must complete 20 weeks of the Program prior to scheduling an Upper Endoscopy
Screening.

BUY IN COMPENSATION

If goals are met and maintained:

1. After three (3) years 50% of Weight Management and 50% of Bariatric Initial payment will be
   refunded
2. After five (5) years 50% of Weight Management and 50% of Bariatric Initial payment will be
   refunded

Volusia Health Network will cover one surgical weight-loss procedure per lifetime, provided that
the member meets the pre-certification requirements on the next page. Additional weight-loss
procedures in the future will be the member’s responsibility.
Smoking Cessation Solutions

In Florida, workplace productivity losses due to smoking are $4.4 billion annually. Although going tobacco-free in the corporate or private business sector can seem difficult, the benefits far outweigh the challenges. Increasingly, businesses are choosing to adopt tobacco-free policies.

Quit Smart: quitsmart.com
Quit Smart is available in a self-help stop smoking kit and, in many communities, as a three-session smoking cessation class that utilizes the kit plus personalized coaching. Quit Smart combines several powerful treatment elements including hypnosis, medication recommendations and a patented simulated cigarette, to produce a potent stop-smoking treatment. The program was developed by Dr. Robert Shipley, Director of the Duke Medical Center Stop Smoking Clinic. Classes are offered at Halifax Health Medical Center or can be held at your facility, if arrangements are made and with a minimum of four participants.

Tools to Quit: northfloridahec.org/tobacco-training-cession/tools-to-quit
Developed by the Florida Area Health Education Centers network, the Tools to Quit (TTQ) is appropriate for those who are unable or unwilling to attend multiple sessions and is appealing to worksites and businesses wishing to assist their employees. This free two hour program provides individuals with the essential tools and information they need in order to quit tobacco successfully. The curriculum and materials in the TTQ program is relevant to all types of tobacco.

Program Details
Each participant is given a participant workbook, a Quit Day Bag with items such as: stress ball, water bottle, sugar free gum, cinnamon toothpicks, and educational materials. A four week supply of Nicotine Replacement Therapy is also provided.

Topics that are addressed during the program include:
- Selecting a quit date
- How to cope with withdrawal from nicotine
- Identifying triggers
- How to handle triggers
- Stress management
- Detailed description of available Nicotine Replacement Therapies