PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION

for the

COLLIER COUNTY GOVERNMENT
EMPLOYEE BENEFIT PLAN

This booklet describes the Plan Benefits
in effect as of January 1, 2025

The Plan has been established for the benefit of
eligible Employees and their Dependents of:

COLLIER COUNTY GOVERNMENT

Claims Processed By:

ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.
2806 South Garfield Street
PO Box 3018
Missoula, MT 59806-3018

Missoula Area Phone Number: (406) 721 - 2222
Toll-Free Number: (800) 877-1122

COVER/SIGNATURE PAGE

Effective January 1, 2025, Collier County Government restates its self-funded Health Care Plan for the benefit of eligible Employees, Retirees and their eligible Dependents entitled, **COLLIER COUNTY GOVERNMENT EMPLOYEE BENEFIT PLAN** (the "Plan").

The purpose of this Plan is to provide reimbursement for Expenses Incurred for covered services, treatment or supplies as a result of Medically Necessary treatment for Illness or Injury of the County's eligible Employees and their eligible Dependents. The County, in conjunction with any required contributions by its Employees, agrees to make payments to the Plan's Trust in order for payments to be made for covered services, treatments or supplies as provided by this Plan.

The County has caused this instrument to be executed as of the day first mentioned above.

COLLIER COUNTY GOVERNMENT

BY: _____

TITLE: _____

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INTRODUCTION

Effective January 1, 2025, Collier County Government, hereinafter referred to as the “County” or “Employer”, restates the benefits, rights and privileges which will pertain to participating Employees, referred to as “Participants,” qualifying Retirees and the eligible Dependents of such Participants or Retirees, as defined, and which benefits are provided through a fund established by the County and referred to as the “Plan”. This booklet describes the Plan in effect as of January 1, 2025.

Coverage provided under this Plan for Employees and their Dependents will be in accordance with the Eligibility, Effective Date, Qualified Medical Child Support Order, Termination, Family and Medical Leave Act and other applicable provisions as stated in this Plan.

Collier County Government (the Plan Sponsor) has retained the services of an independent Plan Supervisor, experienced in claims processing, to handle health claims. The Plan Supervisor for the Plan is:

Allegiance Benefit Plan Management, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

Please read this booklet carefully before incurring any medical expenses. For specific questions regarding coverage or benefits, please refer to the Plan Document, which is available for in the Personnel Office or at the office of the Plan Supervisor, or call or write to Allegiance Benefit Plan Management, Inc. regarding any detailed questions concerning the Plan.

This Plan is not intended to, and cannot be used as worker’s compensation coverage for any Employee or any covered Dependent of an Employee. Therefore, this Plan generally excludes claims related to any activity engaged in for wage or profit including, but not limited to, farming, ranching, part-time and seasonal activities. See Plan Exclusions for specific information.

The information contained in this Plan Document/Summary Plan Description is only a general statement regarding FMLA, COBRA, USERRA, and QMCSO. It is not intended to be and should not be relied upon as complete legal information about those subjects. Covered Persons and Employers should consult their own legal counsel regarding these matters.

HEALTH PLAN QUALIFIERS

Employees and Dependents are eligible for coverage under this Plan, subject to the eligibility criteria of the Plan.

Certain covered Employees (Participants) and their covered spouses may qualify for cost sharing reduction rewards under this Plan. Those rewards are based upon the Health Plan Qualifiers described below The rewards may be different for a Participant than for the Participant's spouse subject to the results of the Health Plan Qualifiers. There are two levels of rewards, Select Rewards and Premium Rewards. The Health Plan Qualifiers for each level of rewards are stated below. There are also required Qualifying Periods to earn those rewards as stated below. Qualifying Periods for Retirees and COBRA Participants will be the same as they were prior to retirement or continuing coverage under COBRA. Plan Qualifiers are specific actions to be completed by an Employee or Retiree and their spouse to determine under which reward level they may qualify for the next Benefit Period.

QUALIFYING PERIODS

1. For spouses a Qualifying Period will be October 1 ending September 30 of every odd year.
2. For Employees a Qualifying Period will be October 1 ending September 30 of every even year.

QUALIFYING GUIDELINES

The following are qualifying guidelines:

1. Paperwork is due to the on-site contracted Health Advocate's office by September 30 (no exceptions);
2. Tobacco Users must enroll in the Smoking Cessation Program by the date designated by the Director of Risk Management and complete the qualifying criteria by September 30;
3. Risk Factors criteria must be completed by September 30.

PLAN QUALIFIERS

The following are Plan Qualifiers that are applicable to both the **Premium and Select Reward Levels** (Plan Qualifiers were determined using Evidence Based Medical Guidelines and may be adjusted annually):

1. **Lab work** -Lab must be drawn by the contracted Lab vendor. The vendor may offer services at patient service centers or at various work sites when scheduled. Calendars will be posted at all work sites. All qualifying lab draws must be completed by the date designated by the Director of Risk Management.

   Eligible Employees/Spouses/Retirees/COBRA need to make an appointment with the contracted lab through the Advocate website at www.chpha.com.

2. **Meet with On-site Health Advocate** - Schedule your appointment with the Health Advocate through www.chpha.com to review the results of your lab draw, and qualifier requirements. The deadline for meetings with the Advocates will be designated by the Director of Risk Management.

   Eligible Retirees/COBRA who do not reside in Collier County will contact the Advocates by phone.

The following are additional Plan Qualifiers for the **Premium Reward Level**:

1. Preventive Care Screening - Required screenings include:

   A. Physicals for all covered Employees and spouses;
   B. Mammograms for female Employees and spouses at age 40 and over; and
   C. Colonoscopies for all covered Employees and spouses at age 50 and over.

Age is determined as of January 1 of the Plan Year. All screenings completed by Network Providers will be covered at 100%, Deductible Waived. Acceptable time-frames of these screenings are listed on the qualifying worksheet given during the Health Advocate meeting.

2. **Tobacco Cessation Program** - This Program is only administered through The MedCenter or The MedCenter North. A certificate of completion will be issued after a follow-up lab test has been completed at either of The MedCenters. The certificate of completion will be provided by the Health Advocate upon completion of the Program.

   Covered Persons who do not reside in Collier County will work with the Health Advocate who will monitor the tobacco cessation program they are engaged in. A certificate of completion must be provided to the on-site contracted Health Advocate by September 30.

There are no Plan Qualifiers to participate in the Basic Reward Level. Participants, Retirees and their spouses automatically qualify for the Basic Reward Level if qualifying requirements for the Select or Premium Reward Levels are not completed by September 30.

NEW HIRES AND NEW SPOUSES

All newly hired Employees, newly eligible Employees and newly covered spouses will be enrolled in the Premium Reward Level and will be required to complete Plan Qualifiers by September 30 of every even year for Employees and every odd year for spouses, and will remain in the Premium Reward Level until the next Qualifying Period.

EMPLOYEES WHO BECOME TOTALLY DISABLED DURING THE QUALIFYING PERIOD

Employees who become Totally Disabled for six (6) months or more during the Qualifying Period and are unable to complete the Plan Qualifiers, will remain in the Reward Level they are currently in until such time Plan Qualifiers can be completed. Verification of the disability should be submitted to the Health Advocates Office.

“Total Disability” or “Totally Disabled” means that a person is prevented from performing the principal functions of the person’s occupation, and as a result, the person has a loss of 20% or more of their pre-disability weekly earnings due to an Accidental Injury, Illness, Mental Illness, Alcoholism and/or Chemical Dependency or Pregnancy.

EMPLOYEES WHO LEAVE AND RETURN TO EMPLOYMENT WITHIN THE CURRENT BENEFIT PERIOD

Employees who leave employment and return within the current Benefit Period will be enrolled in the Reward Level they were in as of the date of termination. If the Employee returns after the current Benefit Period, the Employee will be placed in the Premium Reward Level.

REQUEST FOR ACCOMMODATION OR EXEMPTION

If the Covered Person is unable to meet the Health Plan Qualifiers or needs reasonable accommodation to participate in the cost sharing reduction rewards program, options may be available for alternative program or different means to qualify for cost sharing reduction rewards.

Reasonable Accommodation: The Plan will work with the Covered Person, and the Physician or Licensed Health Care Provider, if applicable, to design a program with reasonable accommodations to participate in the cost sharing reduction rewards program.

Medical Exemption: If the Covered Person can demonstrate that achieving the Health Plan Qualifier requirements is unreasonably difficult to achieve or inadvisable to attempt due to a medical condition, the Covered Person must provide supporting documentation from the Physician or Licensed Health Care Provider within forty-five (45) days for a medical exemption. Covered Persons who cannot achieve the Health Plan Qualifier requirements or alternative program requirements because of a medical issue will be given a waiver or a different option to qualify.

Contact the Plan Administrator for more information.

INVEST IN YOUR HEALTH APPEALS PROCESS

"Invest in Your Health" is the County's health program is for all benefit-eligible Covered Persons of the medical Plan (i.e., Employees, Retirees, and COBRA Participants). Each year, Covered Persons are eligible to participate in activities to qualify for better health care coverage. These activities include a blood draw and biometric screening, meeting with an advocate coach, Preventative Care screenings, and wellness education. If Covered Persons do not complete these qualifiers by the designated deadline (s), the Covered Persons will only qualify for the Basic Group Health Plan or the Select cost share, based upon the qualifier(s) not met. If Covered Persons miss a deadline and wishes to submit an appeal, this procedure below outlines that process.

All appeals must be submitted on the "Invest in Your Health" Appeal Request form and received in the Health Advocate's office no later than November 15 of the qualifying year for coverage effective the subsequent year. All appeals received after this date will be automatically denied.

1. The Covered Person submits the completed and signed appeal to the Health Advocate's office or by email to InvestInYourHealth@chealthpartners.com by November 15. All identifiers are removed before the appeal is forwarded on for review.

2. The Wellness and Benefits staff reviews the anonymous appeal and makes a recommendation to the Director of Risk Management.

3. The Director of Risk Management reviews the anonymous appeal and the recommendation provided by the Wellness and Benefits staff. A final decision is made by the Director of Risk Management to accept or deny the appeal request. The decision is final and no further appeals associated with the request will be entertained.

4. The Health Advocate's office provides the final decision to the Covered Person.

IN-NETWORK BENEFIT

This Plan provides benefits through a group of contracted providers (In-Network Providers). An In-Network Provider means using a provider who is part of the group of contracted providers. Using In-Network providers offers cost-savings advantages because a Covered Person pays only a percentage of the scheduled fee for services provided.

Out-of-Network Provider means a provider who is not an In-Network Provider. A Covered Person who uses an Out-of-Network Provider will pay more and his or her share of the cost may not apply to the Out-of-Pocket Maximum.

To determine if a Physician or Licensed Health Care Provider qualifies as an eligible In-Network Provider under this Plan, please consult Allegiance's website at www.askallegiance.com/ccg to access links for directories of participating providers.

The following benefit provisions apply when a covered service is rendered by a Out-of-Network provider:

1. Charges for an Emergency as defined by this Plan, limited to only those Emergency medical procedures necessary to treat and stabilize an eligible Injury or Illness and then only to the extent that the same are necessary in order for the Covered Person to be transported, at the earliest medically appropriate time to an In-Network Hospital, clinic or other facility, or discharged will be paid at the In-Network level of benefits.

2. Charges which are incurred as a result of and related to confinement in or use of an In-Network Hospital, clinic or other facility only for Out-of-Network services and providers over whom or which the Covered Person does not have any choice in or ability to select will be paid at the In-Network Provider level of benefits. **The Plan UCR limitations will not apply to this exception.**

3. If the provider rendering service is located in Collier County and is not part of the CHP Network but is part of the CIGNA Network, benefits will be paid at the Out-of-Network Provider level of benefits.

4. If the provider rendering service is located outside of Collier County and is not part of the CHP Network but is part of the CIGNA Network, benefits will be paid at the In-Network Provider level of benefits.

5. Charges for Emergency use of an Air Ambulance.

CONTINUITY OF CARE

In the event a provider that a Covered Person is currently receiving services, treatment or care of an Illness or Injury for any of the following terminates its Network affiliation, the Plan will pay the provider at the Network benefit level and allowable amount for a period of up to ninety (90) days after the date the provider terminates its Network affiliation:

1. Pregnancy in the second or third trimester or postpartum care;

2. Continuation of treatment for a chronic or acute medical condition;

3. Active care at an Inpatient facility;

4. A disabling, degenerative, congenital or life threatening Illness;

5. Ongoing treatment of a terminal Illness or serious medical condition; or

6. A Mental Illness or Alcohol and/or Chemical Dependency condition.

To be eligible for this benefit, call the customer service number listed on the Participant's identification card.

SCHEDULE OF MEDICAL BENEFITS - BASIC REWARD LEVEL
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND THE USUAL, CUSTOMARY AND REASONABLE LIMITS OF THE PLAN

THE BENEFIT PERIOD IS A CALENDAR YEAR

COST SHARING PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE (Embedded)		
Per Covered Person per Benefit Period	$2,000	$4,000
Per Family per Benefit Period	$4,000	$8,000
The Deductible applies to all Eligible Expenses, unless specifically stated otherwise. An individual Covered Person cannot receive credit toward the Family Deductible for more than the individual Deductible. The Deductible is combined for both In-Network Providers and Out-of-Network Providers.		
OUT-OF-POCKET MAXIMUM (Embedded)		
Per Covered Person per Benefit Period	$5,200	$14,000
Per Family per Benefit Period	$11,400	$28,000
The Out-of-Pocket Maximum includes the Deductible, Medical Benefit Copayments, and Eligible Expenses in excess of Benefit Period, unless specifically stated otherwise. The Out-of-Pocket Maximum is combined for both In-Network Provider and Out-of-Network Providers. Expenses Incurred for the following do not apply toward the Out-of-Pocket Maximum: 1) any penalty amounts; 2) any charges defined in the **General Exclusions and Limitations** Section; 3) Dental Care expenses due to Illness or Injury.		
BENEFIT PERCENTAGE		
Before satisfaction of Out-of-Pocket Maximum	80%	60%
After satisfaction of Out-of-Pocket Maximum	100%	100%
The Benefit Percentage applies to all Eligible Expenses, unless specifically stated otherwise. Eligible Expenses will be paid by the Plan according to the applicable Benefit Percentage.		
NON-COMPLIANCE PENALTY See Mandatory Case Management		
Non Participation in Case Management Penalty	$1,000	
Non Participation in Notification Provisions	$300	
PHYSICIAN REGIONAL HOSPITAL COPAYMENT	$1,000	
Copayment applies to any non-emergent or scheduled Inpatient admission or Outpatient service. The Copayment is waived for Preventive Care services or screenings performed at Physician Regional.		
Exception to In-Network Provider requirement: In-Network Providers should be used if at all possible. However, for Durable Medical Equipment and other covered medical supplies, if the supply can be purchased at retail or online for an amount less than the Network rate for the same supply, Network cost sharing provisions will apply. The Covered Person must submit an itemized receipt to the Plan Supervisor for claim adjudication. The Plan Supervisor should be contacted in advance of any purchase to obtain the Network rate.		
MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES	Unlimited	

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
ACUPUNCTURE TREATMENT		
	80% after Deductible	60% after Deductible
Benefit Limits: 20 visits Maximum Benefit per Benefit Period **Benefit limits are for services received from Network and Non-Network Providers.**		
ALCOHOLISM AND/OR CHEMICAL DEPENDENCY DISORDERS		
Inpatient Facility Services	80% after Deductible	60% after Deductible
Inpatient Professional Provider Services	80% after Deductible	60% after Deductible
Outpatient Facility Services	80% after Deductible	60% after Deductible
Outpatient Professional Provider Services	80% after Deductible	60% after Deductible
Office Visit Services	80% after Deductible	60% after Deductible
AMBULANCE SERVICE		
Air & Ground Ambulance	80% after In-Network Deductible	
BARIATRIC SURGERY		
	80% after Deductible	60% after Deductible
Only if pre-approved. See Bariatric Program.		
CHIROPRACTIC CARE/SPINAL MANIPULATION/MASSAGE THERAPY		
	80% after Deductible	No Coverage
Benefit Limits: Combined of 20 Treatments Maximum Benefit per Benefit Period "Treatment" includes all services provided during a calendar day, including X-rays **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		
COLONOSCOPY		
Routine Colonoscopy	100%, Deductible Waived	No Coverage
Diagnostic Colonoscopy (See Medical Benefits)	80%, Deductible Waived	No Coverage
COVID-19 VACCINE		
	100%, Deductible Waived	No Coverage

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
DENTAL SERVICES		
	80%, Deductible Waived	60% after Deductible
Dental Care due to an Illness or Injury. See Medical Benefits. After benefits are exhausted under any Dental Plan.		
DURABLE MEDICAL EQUIPMENT		
	80% after Deductible	60% after Deductible
EMERGENCY ROOM SERVICES		
Facility Services for Emergency	80% after In-Network Deductible	
Professional Provider Services for Emergency	80% after In-Network Deductible	
Facility Services for Non-Emergency	80% after Deductible	60% after Deductible
Professional Provider Services for Non-Emergency	80% after Deductible	60% after Deductible
HEARING AIDS (Includes exam and fitting)		
	80% after In-Network Deductible	
Benefit Limits: $5,000 Maximum Benefit every 5 Benefit Periods. **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		
HINGE HEALTH		
	100%, Deductible Waived	
Benefit limited to Employees and Dependents age 18 and older.		
HOME HEALTH CARE		
	80% after Deductible	60% after Deductible
HOSPICE CARE (Includes Bereavement Counseling)		
	80% after Deductible	60% after Deductible
Benefit Limits: Bereavement Counseling is limited to Maximum Lifetime Benefit of 15 visits per family. **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		
HOSPITAL SERVICES OR LONG-TERM ACUTE CARE FACILITY		
Inpatient Facility Services	80% of actual charge after Deductible	60% of actual charge after Deductible
Inpatient Professional Provider Services	80% after Deductible	60% after Deductible
Outpatient Facility Services	80% after Deductible	60% after Deductible
Outpatient Professional Provider Services	80% after Deductible	60% after Deductible

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT IN-NETWORK	OUT-OF-NETWORK
INFERTILITY		
Diagnostic testing to determine infertility	80% after Deductible	60% after Deductible
Infertility Treatment	No Benefit	No Benefit
MAMMOGRAMS		
Routine Mammograms	100%, Deductible Waived	No Coverage
Diagnostic Mammograms	80% after Deductible	60% after Deductible
MENTAL ILLNESS		
Inpatient Facility Services	80% after Deductible	60% after Deductible
Inpatient Professional Provider Services	80% after Deductible	60% after Deductible
Outpatient Facility Services	80% after Deductible	60% after Deductible
Outpatient Professional Provider Services	80% after Deductible	60% after Deductible
Office Visit Services	80% after Deductible	60% after Deductible
Emotional Wellness Program through CHP	100%, Deductible Waived	Not Applicable
ON-SITE CLINIC SERVICES		
MedCenter Consultations	100%, Deductible Waived	Not Applicable
The on-site clinic services are available to all eligible Participants and Dependents 15 years or older who are covered under the Collier County Government Employee Benefit Plan. A referral from the clinic to an In-Network Provider will be processed as an In-Network claim. For medical services only, age fifteen (15) years and older. No age limits on other on-site services.		
OUTPATIENT LAB SERVICES		
	80% after Deductible	60% after Deductible
OUTPATIENT RENAL DIALYSIS BENEFIT		
	80% after Deductible	60% after Deductible
For Out-of-Network Medical Services/Supplies: Maximum Benefit 125% of Medicare Allowable ESRD Related Drugs: Maximum Benefit of 125% of the Average Sales Price (ASP)		
OUTPATIENT THERAPIES (PHYSICAL, SPEECH, OCCUPATIONAL, AQUATIC)		
	80% after Deductible	60% after Deductible
PAIN MANAGEMENT		
	80% after Deductible	60% after Deductible
Epidurals, facet blocks and nerve stimulators are limited to a combined Maximum Benefit of 6 procedures per Benefit Period. Other procedures are not limited. **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT IN-NETWORK	OUT-OF-NETWORK
PHYSICIAN SERVICES		
Office Visits	80% after Deductible	60% after Deductible
PREVENTIVE CARE		
	100%, Deductible Waived	No Coverage
Covered Services: ♦ Well-Child Care ♦ Physical examinations ♦ Pelvic examination and pap smear ♦ Laboratory and testing ♦ Hearing and vision screening ♦ Breast cancer screening (e.g., Mammograms, Magnetic Resonance Imaging (MRIs), Ultrasounds and similar breast cancer screening services) ♦ Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE) ♦ Cardiovascular screening blood tests ♦ Colorectal cancer screening tests ♦ Vaccinations and Immunizations recommended by Physician ♦ BRCA1 and BRCA2 when medically indicated ♦ Nutritional counseling ♦ Well Women Preventive Care subject to Plan limitations on sterilization procedures Complete list of recommended preventive services can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/. If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services. **See Medical Benefits Section.**		
PREVENTIVE/PROPHYLACTIC MASTECTOMY/OOPHORECTOMY		
	80% after Deductible	60% after Deductible
RADIATION THERAPY/CHEMOTHERAPY/HOME INFUSION THERAPY		
	80% after Deductible	60% after Deductible
ROUTINE QUALIFIER SERVICES		
	100%, Deductible Waived	No Coverage
See Medical Benefits section.		
SCALP HAIR PROSTHESIS/WIGS/HAIR PIECES		
	80% after In-Network Deductible	
Benefit Limits: One (1) wig/hair piece up to $500 Maximum Benefit every two (2) Benefit Periods. **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
SKILLED NURSING FACILITY AND REHABILITATION FACILITY		
	80% after Deductible	60% after Deductible
TELEMEDICINE		
Recuro Health Consultations	100% after $5 Copayment, Deductible Waived	Not Applicable
For further details, please consult www.recurohealth.com or call (855) 6RECURO.		
Telemedicine other than Recuro Health	80% after Deductible	60% after Deductible
MedCenter Telemedicine Consultation	100%, Deductible Waived	Not Applicable
For further details, please refer to the county's website; https://www.colliercountyfl.gov/benefits.		
Emotional Wellness Program through CHP Telemedicine Consultation	100%, Deductible Waived	Not Applicable
For further details, please call the Emotional Wellness Program through CHP at (239) 659-7751.		
TOBACCO CESSATION (Referral from The MedCenter is required)		
	100%, Deductible and Copayment Waived	Not Applicable
Referral from The MedCenter is required.		
URGENT CARE FACILITY		
	80% after Deductible	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS - SELECT REWARD LEVEL
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND THE USUAL, CUSTOMARY AND REASONABLE LIMITS OF THE PLAN

THE BENEFIT PERIOD IS A CALENDAR YEAR

COST SHARING PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE (Embedded)		
Per Covered Person per Benefit Period	$700	$1,400
Per Family per Benefit Period	$1,400	$2,800
The Deductible applies to all Eligible Expenses, unless specifically stated otherwise. An individual Covered Person cannot receive credit toward the Family Deductible for more than the individual Deductible. The Deductible is combined for both In-Network Providers and Out-of-Network Providers.		
OUT-OF-POCKET MAXIMUM (Embedded)		
Per Covered Person per Benefit Period	$3,400	$6,400
Per Family per Benefit Period	$6,800	$12,800
The Out-of-Pocket Maximum includes the Deductible, Medical Benefit Copayments and Eligible Expenses in excess of Benefit Period, unless specifically stated otherwise. The Out-of-Pocket Maximum is combined for both In-Network Provider and Out-of-Network Providers. Expenses Incurred for the following do not apply toward the Out-of-Pocket Maximum: 1) any penalty amounts; 2) any charges defined in the **General Exclusions and Limitations** Section; 3) Dental Care expenses due to Illness or Injury.		
BENEFIT PERCENTAGE		
Before satisfaction of Out-of-Pocket Maximum	80%	60%
After satisfaction of Out-of-Pocket Maximum	100%	100%
The Benefit Percentage applies to all Eligible Expenses, unless specifically stated otherwise. Eligible Expenses will be paid by the Plan according to the applicable Benefit Percentage.		
NON-COMPLIANCE PENALTY See Mandatory Case Management		
Non Participation in Case Management Penalty	$1,000	
Non Participation in Notification Provisions	$300	
PHYSICIAN REGIONAL HOSPITAL COPAYMENT	$1,000	
Copayment applies to any non-emergent or scheduled Inpatient admission or Outpatient service. The Copayment is waived for Preventive Care services or screenings performed at Physician Regional.		
Exception to In-Network Provider requirement: In-Network Providers should be used if at all possible. However, for Durable Medical Equipment and other covered medical supplies, if the supply can be purchased at retail or online for an amount less than the Network rate for the same supply, Network cost sharing provisions will apply. The Covered Person must submit an itemized receipt to the Plan Supervisor for claim adjudication. The Plan Supervisor should be contacted in advance of any purchase to obtain the Network rate.		
MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES	Unlimited	

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT IN-NETWORK	OUT-OF-NETWORK
ACUPUNCTURE TREATMENT		
	80% after Deductible	60% after Deductible
Benefit Limits: 20 visits Maximum Benefit per Benefit Period **Benefit limits are for services received from Network and Non-Network Providers.**		
ALCOHOLISM AND/OR CHEMICAL DEPENDENCY		
Inpatient Facility Services	80% after Deductible	60% after Deductible
Inpatient Professional Provider Services	80% after Deductible	60% after Deductible
Outpatient Facility Services	80% after Deductible	60% after Deductible
Outpatient Professional Provider Services	80% after Deductible	60% after Deductible
Office Visit Services	100% after $40 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	60% after Deductible
AMBULANCE SERVICE		
Air & Ground Ambulance	80% after In-Network Deductible	
BARIATRIC SURGERY		
	80% after Deductible	60% after Deductible
Only if pre-approved. See Bariatric Program.		
CHIROPRACTIC CARE/SPINAL MANIPULATION/MASSAGE THERAPY		
	100% after $40 Copayment, Deductible Waived	No Coverage
Benefit Limits: Combined of 20 Treatments Maximum Benefit per Benefit Period "Treatment" includes all services provided during a calendar day, including X-rays **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		
COLONOSCOPY		
Routine Colonoscopy	100%, Deductible Waived	No Coverage
Diagnostic Colonoscopy (See Medical Benefits)	80%, Deductible Waived	No Coverage

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT IN-NETWORK	OUT-OF-NETWORK
COVID-19 VACCINE		
	100%, Deductible Waived	No Coverage
DENTAL SERVICES		
	80%, Deductible Waived	60% after Deductible
Dental Care due to an Illness or Injury. See Medical Benefits section. After benefits are exhausted under any Dental Plan.		
DURABLE MEDICAL EQUIPMENT		
	80% after Deductible	60% after Deductible
EMERGENCY ROOM SERVICES		
Facility Services for Emergency	$100 Copayment per visit, then 80% after In-Network Deductible	
Professional Provider Services for Emergency	80% after In-Network Deductible	
Facility Services for Non-Emergency	$100 Copayment per visit, then 80% after Deductible	$100 Copayment per visit, then 60% after Deductible
Professional Provider Services for Non-Emergency	80% after Deductible	60% after Deductible
Note: The Emergency Room Copayment will be waived if the person is admitted directly as an Inpatient to the Hospital and Inpatient Hospital benefits will apply.		
HEARING AIDS (Includes exam and fitting)		
	80% after In-Network Deductible	
Benefit Limits: $5,000 Maximum Benefit every 5 Benefit Periods **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		
HINGE HEALTH		
	100%, Deductible Waived	
Benefit limited to Employees and Dependents age 18 and older.		
HOME HEALTH CARE		
	80% after Deductible	60% after Deductible
HOSPICE CARE (Includes Bereavement Counseling)		
	80% after Deductible	60% after Deductible
Benefit Limits: Bereavement Counseling is limited to Maximum Lifetime Benefit of 15 visits per family. **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	-OF-NETWORK
HOSPITAL SERVICES OR LONG-TERM ACUTE CARE FACILITY HOSPITAL		
Inpatient Facility Services	80% of actual charge after Deductible	60% of actual charge after Deductible
Inpatient Professional Provider Services	80% after Deductible	60% after Deductible
Outpatient Facility Services	80% after Deductible	60% after Deductible
Outpatient Professional Provider Services	80% after Deductible	60% after Deductible
INFERTILITY - DIAGNOSTIC TESTING TO DETERMINE INFERTILITY		
Inpatient/Outpatient Services, Except for the Office Visit	80% after Deductible	60% after Deductible
Primary Care Physician Office Visit Charge	100% after $40 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	60% after Deductible
Specialty Care Physician Office Visit Charge	100% after $60 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	60% after Deductible
All Other Services/Supplies other than Evaluation and Management Charges Performed in a Physician's Office	100% of the first $500 per visit, Deductible Waived, then 80% after Deductible	60% after Deductible
INFERTILITY - TREATMENT OF INFERTILITY		
	No Benefit	No Benefit
MAMMOGRAMS		
Routine Mammograms	100%, Deductible Waived	No Coverage
Diagnostic Mammograms	80% after Deductible	60% after Deductible
OUTPATIENT LAB SERVICES		
	100% of the first $500 per visit, Deductible Waived, then 80% after Deductible	60% after Deductible

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT RENAL DIALYSIS BENEFIT		
	80% after Deductible	60% after Deductible
For Out-of-Network Medical Services/Supplies: Maximum Benefit 125% of Medicare Allowable ESRD Related Drugs: Maximum Benefit of 125% of the Average Sales Price (ASP)		
OUTPATIENT THERAPIES (PHYSICAL, SPEECH, OCCUPATIONAL, AQUATIC)		
	100% after $40 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	60% after Deductible
PAIN MANAGEMENT		
	80% after Deductible	60% after Deductible
Epidurals, facet blocks and nerve stimulators are limited to a combined Maximum Benefit of 6 procedures per Benefit Period. Other procedures are not limited. **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		
PHYSICIAN SERVICES		
Inpatient/Outpatient Services, except for office visits	80% after Deductible	60% after Deductible
Primary Care Physician Office Visit Charge	100% after $40 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	60% after Deductible
Specialist Physician Office Visit Charge	100% after $60 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	60% after Deductible
All Other Services/Supplies other than evaluation and management charges performed in a Physician's office.	100% of the first $500 per visit, Deductible Waived, then 80% after Deductible	60% after Deductible
If more than one Physician is seen in the same clinic on the same day, only one Copayment will apply.		

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
	100%, Deductible Waived	No Coverage
Covered Services: ♦ Well-Child Care ♦ Physical examinations ♦ Pelvic examination and pap smear ♦ Laboratory and testing ♦ Hearing and vision screening ♦ Breast cancer screening (e.g., Mammograms, Magnetic Resonance Imaging (MRIs), Ultrasounds and similar breast cancer screening services) ♦ Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE) ♦ Cardiovascular screening blood tests ♦ Colorectal cancer screening tests ♦ Vaccinations and Immunizations recommended by Physician ♦ BRCA1 and BRCA2 when medically indicated ♦ Nutritional counseling ♦ Well Women Preventive Care subject to Plan limitations on sterilization procedures Complete list of recommended preventive services can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/. If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services. **See Medical Benefits section.**		
PREVENTIVE/PROPHYLACTIC MASTECTOMY/OOPHORECTOMY		
	80% after Deductible	60% after Deductible
RADIATION THERAPY/CHEMOTHERAPY/HOME INFUSION THERAPY		
	80% after Deductible	60% after Deductible
ROUTINE QUALIFIER SERVICES		
	100%, Deductible Waived	No Coverage
See Medical Benefits section.		
SCALP HAIR PROSTHESIS/WIGS/HAIR PIECES		
	80% after In-Network Deductible	
Benefit Limits: One (1) wig/hair piece up to $500 Maximum Benefit every two (2) Benefit Periods. **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		
SKILLED NURSING FACILITY AND REHABILITATION FACILITY		
	80% after Deductible	60% after Deductible

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT IN-NETWORK	OUT-OF-NETWORK
TELEMEDICINE		
Recuro Health Consultations	100% after $5 Copayment, Deductible Waived	Not Applicable
For further details, please consult www.recurohealth.com or call (855) 6RECURO.		
Primary Care Physician Telemedicine other than Recuro Health	100% after $40 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	60% after Deductible
Specialist Physician Telemedicine other than Recuro Health	100% after $60 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	60% after Deductible
MedCenter Telemedicine Consultation	100%, Deductible Waived	Not Applicable
For further details, please refer to the county's website; https://www.colliercountyfl.gov/benefits.		
Emotional Wellness Program through CHP Telemedicine Consultation	100%, Deductible Waived	Not Applicable
For further details, please call the Emotional Wellness Program through CHP at (239) 659-7751.		
TOBACCO CESSATION		
	100%, Deductible and Copayment Waived	Not Applicable
Referral from The MedCenter is required,		
URGENT CARE FACILITY		
	80% after Deductible	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS - PREMIUM REWARD LEVEL
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND THE USUAL, CUSTOMARY AND REASONABLE LIMITS OF THE PLAN

THE BENEFIT PERIOD IS A CALENDAR YEAR

COST SHARING PROVISIONS	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE (Embedded)		
Per Covered Person per Benefit Period	$400	$800
Per Family per Benefit Period	$800	$1,600
The Deductible applies to all Eligible Expenses, unless specifically stated otherwise. An individual Covered Person cannot receive credit toward the Family Deductible for more than the individual Deductible. The Deductible is combined for both In-Network Providers and Out-of-Network Providers.		
OUT-OF-POCKET MAXIMUM (Embedded)		
Per Covered Person per Benefit Period	$1,800	$3,800
Per Family per Benefit Period	$3,600	$7,600
The Out-of-Pocket Maximum includes the Deductible, Medical Benefit Copayments and Eligible Expenses in excess of Benefit Period, unless specifically stated otherwise. The Out-of-Pocket Maximum is combined for both In-Network Provider and Out-of-Network Providers. Expenses Incurred for the following do not apply toward the Out-of-Pocket Maximum: 1) any penalty amounts; 2) any charges defined in the **General Exclusions and Limitations** Section; 3) Dental Care expenses due to Illness or Injury.		
BENEFIT PERCENTAGE		
Before satisfaction of Out-of-Pocket Maximum	80%	70%
After satisfaction of Out-of-Pocket Maximum	100%	100%
The Benefit Percentage applies to all Eligible Expenses, unless specifically stated otherwise. Eligible Expenses will be paid by the Plan according to the applicable Benefit Percentage.		
NON-COMPLIANCE PENALTY See Mandatory Case Management		
Non Participation in Case Management Penalty	$1,000	
Non Participation in Notification Provisions	$300	
PHYSICIAN REGIONAL HOSPITAL COPAYMENT	$1,000	
Copayment applies to any non-emergent or scheduled Inpatient admission or Outpatient service. The Copayment is waived for Preventive Care services or screenings performed at Physician Hospital.		
Exception to In-Network Provider requirement: In-Network Providers should be used if at all possible. However, for Durable Medical Equipment and other covered medical supplies, if the supply can be purchased at retail or online for an amount less than the Network rate for the same supply, Network cost sharing provisions will apply. The Covered Person must submit an itemized receipt to the Plan Supervisor for claim adjudication. The Plan Supervisor should be contacted in advance of any purchase to obtain the Network rate.		
MAXIMUM LIFETIME BENEFIT FOR ALL CAUSES	Unlimited	

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
ACUPUNCTURE		
	80% after Deductible	70% after Deductible
Benefit Limits: 20 Visits Maximum Benefit per Benefit Period **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		
ALCOHOLISM AND/OR CHEMICAL DEPENDENCY DISORDERS		
Inpatient Facility Services	80% after Deductible	70% after Deductible
Inpatient Professional Provider Services	80% after Deductible	70% after Deductible
Outpatient Facility Services	100% after $25 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	70% after Deductible
Outpatient Professional Provider Services	80% after Deductible	70% after Deductible
Office Visit Services	100% after $25 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	70% after Deductible
AMBULANCE SERVICES		
Air & Ground Ambulance	80% after In-Network Deductible	
BARIATRIC SURGERY		
	80% after Deductible	70% after Deductible
Only if pre-approved. See Bariatric Program.		
CHIROPRACTIC CARE/SPINAL MANIPULATION/MASSAGE THERAPY		
	100% after $25 Copayment per Visit, Deductible Waived	No Coverage
Benefit Limits: Combined of 20 Treatments Maximum Benefit per Benefit Period "Treatment" includes all services provided during a calendar day, including X-rays **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
COLONOSCOPY		
Routine Colonoscopy	100%, Deductible Waived	No Coverage
Diagnostic Colonoscopy (See Medical Benefits)	80%, Deductible Waived	No Coverage
COVID-19 VACCINE		
	100%, Deductible Waived	No Coverage
DENTAL SERVICES		
	80%, Deductible Waived	70% after Deductible
Dental Care due to an Illness or Injury. See Medical Benefits. After benefits are exhausted under any Dental Plan.		
DURABLE MEDICAL EQUIPMENT		
	80% after Deductible	70% after Deductible
EMERGENCY ROOM SERVICES		
Facility Services for Emergency	$50 Copayment per visit, then 80% after In-Network Deductible	
Professional Provider Services for Emergency	80% after In-Network Deductible	
Facility Services for Non-Emergency	$100 Copayment per visit, then 80% after Deductible	$100 Copayment per visit, then 70% after Deductible
Professional Provider Services for Non-Emergency	80% after Deductible	70% after Deductible
Note: The Emergency Room Copayment will be waived if the person is admitted directly as an Inpatient to the Hospital and Inpatient Hospital benefits will apply.		
HEARING AIDS (Includes exam and fitting)		
	80% after In-Network Deductible	
Benefit Limits: $5,000 Maximum Benefit every 5 Benefit Periods. **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		
HINGE HEALTH		
	100%, Deductible Waived	
Benefit limited to Employees and Dependents age 18 and older.		
HOME HEALTH CARE		
	80% after Deductible	70% after Deductible

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
HOSPICE CARE (Includes Bereavement Counseling)		
	80% after Deductible	70% after Deductible
Benefit Limits: Bereavement Counseling is limited to Maximum Lifetime Benefit of 15 visits per family. **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		
HOSPITAL SERVICES OR LONG-TERM ACUTE CARE FACILITY HOSPITAL		
Inpatient Facility Services	~~80% after Deductible~~ 80% of actual charge after Deductible	~~70% after Deductible~~ 70% of actual charge after Deductible
Inpatient Professional Provider Services	80% after Deductible	70% after Deductible
Outpatient Facility Services	80% after Deductible	70% after Deductible
Outpatient Professional Provider Services	80% after Deductible	70% after Deductible
INFERTILITY - DIAGNOSTIC TESTING TO DETERMINE INFERTILITY		
Inpatient/Outpatient Services, Except for the Office Visit	80% after Deductible	70% after Deductible
Primary Care Physician Office Visit Charge	100% after $25 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	70% after Deductible
Specialty Care Physician Office Visit Charge	100% after $30 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	70% after Deductible
All Other Services/Supplies other than Evaluation and Management Charges Performed in a Physician's Office	100% of the first $500 per visit, Deductible Waived, then 80% after Deductible	70% after Deductible

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
INFERTILITY - TREATMENT OF INFERTILITY		
	No Benefit	No Benefit
MAMMOGRAMS		
Routine Mammograms	100%, Deductible Waived	No Coverage
Diagnostic Mammograms	80% after Deductible	70% after Deductible
MENTAL ILLNESS		
Inpatient Facility Services	80% after Deductible	70% after Deductible
Inpatient Professional Provider Services	80% after Deductible	70% after Deductible
Outpatient Facility Services	100% after $25 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	70% after Deductible
Outpatient Professional Provider Services	80% after Deductible	70% after Deductible
Office Visit Services	100% after $25 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	70% after Deductible
Emotional Wellness Program through CHP	100%, Deductible Waived	Not Applicable
ON-SITE CLINIC SERVICES		
MedCenter Consultation	100%, Deductible Waived	Not Applicable
The on-site clinic services are available to all eligible Participants and Dependents who are covered under the Collier County Government Employee Benefit Plan. A referral from the clinic to an In-Network Provider will be processed as an In-Network claim. For medical services only, age fifteen (15) years and older. No age limits on other on-site services.		
OUTPATIENT LAB SERVICES		
	100% of the first $500 per visit, Deductible Waived, then 80% after Deductible	70% after Deductible

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT RENAL DIALYSIS BENEFIT		
	80% after Deductible	100% after Deductible
For Out-of-Network Medical Services/Supplies: Maximum Benefit 125% of Medicare Allowable ESRD Related Drugs: Maximum Benefit of 125% of the Average Sales Price (ASP).		
OUTPATIENT THERAPIES (PHYSICAL, SPEECH, OCCUPATIONAL, AQUATIC)		
	100% after $35 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	70% after Deductible
PAIN MANAGEMENT		
	80% after Deductible	70% after Deductible
Epidurals, facet blocks and nerve stimulators are limited to a combined Maximum Benefit of 6 procedures per Benefit Period. Other procedures are not limited. **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		
PHYSICIAN SERVICES		
Inpatient/Outpatient Services, except for office visits	80% after Deductible	70% after Deductible
Primary Care Physician Office Visit Charge	100% after $25 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	70% after Deductible
Specialist Physician Office Visit Charge	100% after $35 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	70% after Deductible
All Other Services/Supplies other than evaluation and management charges performed in a Physician's office.	100% of the first $500 per visit, Deductible Waived, then 80% after Deductible	70% after Deductible
If more than one Physician is seen in the same clinic on the same day, only one Copayment will apply.		

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
	100%, Deductible Waived	No Coverage
Covered Services: ♦ Well-Child Care ♦ Physical examinations ♦ Pelvic examination and pap smear ♦ Laboratory and testing ♦ Hearing and vision screening ♦ Breast cancer screening (e.g., Mammograms, Magnetic Resonance Imaging (MRIs), Ultrasounds and similar breast cancer screening services) ♦ Prostate cancer screening Prostate-specific Antigen (PSA) or Digital Rectal Examination (DRE) ♦ Cardiovascular screening blood tests ♦ Colorectal cancer screening tests ♦ Vaccinations and Immunizations recommended by Physician ♦ BRCA1 and BRCA2 when medically indicated ♦ Nutritional counseling ♦ Well Women Preventive Care subject to Plan limitations on sterilization procedures Complete list of recommended preventive services can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/. If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care and will be subject to the cost sharing that applies to those specific services. **See Medical Benefits Section**.		
PREVENTIVE/PROPHYLACTIC MASTECTOMY/OOPHORECTOMY		
	80% after Deductible	70% after Deductible
RADIATION THERAPY/CHEMOTHERAPY/HOME INFUSION THERAPY		
	80% after Deductible	70% after Deductible
ROUTINE QUALIFIER SERVICES		
	100%, Deductible Waived	No Coverage
See Medical Benefits Section.		
SCALP HAIR PROSTHESIS, WIGS, HAIR PIECES		
	80% after In-Network Deductible	
Benefit Limits: One (1) wig/hair piece up to $500 Maximum Benefit every two (2) Benefit Periods. **Benefit limits are for services received from In-Network and Out-of-Network Providers.**		
SKILLED NURSING FACILITY AND REHABILITATION FACILITY		
	80% after Deductible	70% after Deductible

TYPE OF SERVICE/LIMITATIONS	BENEFIT PERCENTAGE/COPAYMENT	
	IN-NETWORK	OUT-OF-NETWORK
TELEMEDICINE		
Recuro Health Consultations	100% after $5 Copayment, Deductible Waived	Not Applicable
For further details, please consult www.recurohealth.com or call (855) 6RECURO.		
Primary Care Physician Telemedicine other than Recuro Health	100% after $25 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	70% after Deductible
Specialist Physician Telemedicine other than Recuro Health	100% after $35 Copayment of the first $500 per visit, Deductible Waived, then 80% after Deductible	70% after Deductible
MedCenter Telemedicine Consultation	100%, Deductible Waived	Not Applicable
For further details, please refer to the county's website; https://www.colliercountyfl.gov/benefits.		
Emotional Wellness Program through CHP Telemedicine Consultation	100%, Deductible Waived	Not Applicable
For further details, please call the Emotional Wellness Program through CHP at (239) 659-7751.		
TOBACCO CESSATION		
	100%, Deductible and Copayment Waived	Not Applicable
Referral from The MedCenter is required.		
URGENT CARE FACILITY		
	80% after Deductible	70% after Deductible

PHARMACY BENEFIT

Prescription drug charges are payable only through the Plan's Pharmacy Benefit Manager (PBM) program, which program is sponsored in conjunction with and is an integral part of this Plan. Coinsurance does not serve to satisfy the Medical Benefits Deductible or Out-of-Pocket Maximum. However, Pharmacy Coinsurance does apply toward the applicable Pharmacy Benefit Out-of-Pocket Maximum. **The Pharmacy Benefit Manager (PBM) will provide separate information for details regarding Network pharmacies, Preferred Brand prescriptions and Specialty Drugs upon enrollment for coverage under this Plan. Additional information regarding Prescription Drug Benefits is also available at: www.navitus.com or by calling (855) 673-6504.**

Generic Preferred - Member choice (DAW2) - If the Physician does not prescribe "Dispense as Written" (DAW), and there is a generic alternative for the prescription drug, and the Covered Person chooses a brand name instead, the Covered Person must pay the difference in cost between the generic and brand name medication plus the applicable brand Coinsurance amount which amount does not apply towards the Deductible or Out-of-Pocket Maximum.

There is no coordination of benefits for Pharmacy Benefits.

PREMIUM REWARD LEVEL - COST SHARING PROVISIONS

Pharmacy Deductible (combined Retail and Mail Order) per Benefit Period
Per Covered Person $50
Per Family $100

Pharmacy Benefit Out-of-Pocket Maximum per Benefit Period
(Includes the Pharmacy Deductible and applicable Coinsurance)
Per Covered Person $500
Per Family $1,000

Pharmacy Coinsurance is waived after satisfaction of the Pharmacy Out-of-Pocket Maximum.

The following are payable at 100% and are not subject to any Deductible or Coinsurance:

1. Prescribed Tier 1 contraceptives or Tier 2 if Tier 1 is unavailable;
2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider; and
3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/;
4. Navitus complete Vaccine list.

Premium Reward Level - Coinsurance per Prescription			
Drug Type	**Retail - PBM Network**	**Member Submit***	**Mail Order**
Tier 1	20%	20%	20%
Tier 2	20%	20%	20%
Tier 3	40%	40%	40%
*For Member Submit prescriptions, the PBM will reimburse the contract cost of the prescription drug, less the applicable Coinsurance per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription. Claims from non-participating pharmacies are not permitted.			

SELECT REWARD LEVEL - COST SHARING PROVISIONS

Pharmacy Deductible (combined Retail and Mail Order) per Benefit Period
Per Covered Person $200
Per Family $400

Pharmacy Benefit Out-of-Pocket Maximum per Benefit Period
(Includes the Pharmacy Deductible and applicable Coinsurance)
Per Covered Person $800
Per Family $1,600

Pharmacy Coinsurance is waived after satisfaction of the Pharmacy Out-of-Pocket Maximum.

The following are payable at 100% and are not subject to any Deductible or Coinsurance:

1. Prescribed Tier 1 contraceptives or Tier 2 if Tier 1 is unavailable;
2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider; and
3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/
4. Navitus complete Vaccine list.

Select Reward Level - Coinsurance per Prescription			
Drug Type	**Retail - PBM Network**	**Member Submit***	**Mail Order**
Tier 1	20%	20%	20%
Tier 2	20%	20%	20%
Tier 3	40%	40%	40%
*For Member Submit prescriptions, the PBM will reimburse the contract cost of the prescription drug, less the applicable Coinsurance per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription. Claims from non-participating pharmacies are not permitted.			

BASIC REWARD LEVEL - COST SHARING PROVISIONS

Pharmacy Deductible (combined Retail and Mail Order) per Benefit Period
Per Covered Person $400
Per Family $800

Pharmacy Benefit Out-of-Pocket Maximum per Benefit Period
(Includes the Pharmacy Deductible and applicable Coinsurance)
Per Covered Person $1,400
Per Family $2,800

Pharmacy Coinsurance is waived after satisfaction of the Pharmacy Out-of-Pocket Maximum.

The following are payable at 100% and are not subject to any Deductible or Coinsurance:

1. Prescribed Tier 1 contraceptives or Tier 2 if Tier 1 is unavailable;
2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider; and

3. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/
4. Navitus complete Vaccine list.

Basic Reward Level - Coinsurance per Prescription			
Drug Type	**Retail - PBM Network**	**Member Submit***	**Mail Order**
Tier 1	30%	30%	30%
Tier 2	30%	30%	30%
Tier 3	50%	50%	50%
*For Member Submit prescriptions, the PBM will reimburse the contract cost of the prescription drug, less the applicable Coinsurance per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription. Claims from non-participating pharmacies are not permitted.			

COVERAGE

Coverage for prescription drugs will include only those drugs requiring a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, and that are Medically Necessary for the treatment of an Illness or Injury.

Coverage also includes prescription drugs or supplies that require a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, as follows:

1. Self-administered contraceptives, NuvaRing, injectables, transdermals, IUDs, implants, diaphragms, and over-the-counter FDA approved female contraceptives with a written prescription by a Physician or Licensed Health Care Provider.

   Contraceptive Management, injectable contraceptives and contraceptive devices are also covered under the Preventive Care Benefit of this Plan.

2. Agents used in the treatment of acne and/or for Cosmetic purposes subject to medical review.

3. Erectile Dysfunction subject to quantity limits.

4. Vaccines; Navitus complete list and as covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

5. Legend vitamins (oral only).

6. Legend fluoride products (oral only).

7. Diabetic supplies including; syringes, Pen needles, alcohol swabs, blood test strips, blood glucose meters, blood glucose calibration solutions, lancets and lancet devices.

8. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider and if covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/. After this requirement has been met, applicable cost sharing applies.

9. Over-the-counter (OTC) medications only when prescribed by a Physician or Licensed Health Care Provider, and only if listed as an A or B recommendation as a Preventive Service covered under the Affordable Care Act which can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

10. Compound medications.

SERVICE OPTIONS

The Program includes the following Service Options for obtaining prescriptions under the Pharmacy Benefit:

PBM Network Prescriptions: Available only through a retail pharmacy that is part of the PBM Network. The pharmacy will bill the Plan directly for that part of the prescription cost that exceeds the Coinsurance (Coinsurance amount must be paid to pharmacy at time of purchase). **The prescription identification card is required for this option.**

Member Submit Prescriptions: Available only if the prescription identification card is not used at a PBM pharmacy. **Prescriptions must be paid for at the point of purchase and the prescription drug receipt must be submitted to the Pharmacy Benefit Manager (PBM), along with a reimbursement form (Direct Reimbursement). The PBM will reimburse the contract cost of the prescription drug, less the applicable Coinsurance per Prescription. Contract cost is the PBM's discounted cost of the prescription drug. Reimbursement will not exceed what the PBM would have reimbursed for a Network Prescription. Claims from non-participating pharmacies are not permitted.**

Mail Order Prescriptions: Available only through a licensed pharmacy that is part of the PBM Network which fills prescriptions and delivers them to Covered Persons through the United States Postal Service, United Parcel Service or other delivery service. **The pharmacy will bill the Plan directly for prescription costs that exceed the Coinsurance.**

Specialty Drug(s): These medications are generic or non-generic drugs classified by the Plan and listed by the PBM as Specialty Drugs and require special handling (e.g., most injectable drugs other than insulin). Specialty drugs must be obtained from a preferred specialty pharmacy. **A list of specialty drugs and preferred specialty pharmacies may be obtained from the PBM or Plan Supervisor.**

DRUG OPTIONS

The drug options available are:

Tier 1: Preferred generics and some lower cost brand products

Tier 2: Preferred brand products and some high cost non-preferred generics

Tier 3: Non-preferred brand products (could include some high cost non-preferred generics)

COINSURANCE

"Coinsurance" means a dollar amount fixed percentage per prescription payable to the pharmacy at the time of service. Coinsurance amounts are specifically stated in this section. Coinsurance is not payable by the Plan and does not serve to satisfy the Medical Benefits Deductible or Out-of-Pocket Maximum. However, Pharmacy Coinsurance does apply toward the applicable Pharmacy Benefit Out-of-Pocket Maximum.

SUPPLY LIMITS

Supply is limited to ninety (90) days for PBM Network, Member Submit Prescriptions and Mail Order Prescriptions.

Prescription drug refills are not allowed until 75% of the prescribed day supply is used for Retail prescriptions, or 70% for Mail Order prescriptions. For Opioid prescriptions, drug refills are not allowed until 85% of the prescribed day supply is used for Opioid Retail prescriptions or 80% for Opioid Mail Order prescriptions.

The amount of certain medications are limited to promote safe, clinically appropriate drug usage. Any additional prescribed supply exceeding any clinically appropriate limits will be reviewed for Medical Necessity. A current list of applicable quantity limits can be obtained by contacting the PBM at the number listed on the identification card.

STEP THERAPY PROGRAM

Step Therapy is a program to help increase appropriate utilization of certain drugs and influence the process of managing costs.

SPECIALTY COPAYMENT ASSISTANCE PROGRAM

This Plan offers a Specialty Copayment Assistance Program for certain specialty drugs included in the specialty tier and dispensed only through the specialty pharmacy, Lumicera. This program will properly manage the Covered Person's expenses for eligible specialty medications while also lowering the Plan's overall cost if copayment assistance is available. Under the program, the Covered Person's specialty medications are subject to a Copayment/coinsurance of 30%. However, this program will cap the Covered Person's total payment at $0 after utilization of available copayment assistance. Only the amount the Covered Person pays out-of-pocket will apply to the Deductible and/or Out-of-Pocket Maximum. If a specialty drug does not qualify or is removed from the program, the Covered Person's Copayment will default to the formulary's current tiered Copayment/coinsurance.

PRIOR AUTHORIZATION

Certain drugs require approval before the drug can be dispensed. A current list of drugs that require prior authorization can be obtained by contacting the PBM at the number listed on the Participant's identification card.

EXCLUSIONS

Prescription drugs or supplies in the following categories are specifically excluded:

1. Cosmetic only indications including, but not limited to, photo-aged skin products (Renova); hair growth or hair removal agents (Propecia, Vaniqa); injectable Cosmetics (Botox Cosmetic).

2. Dermatology: Agents used in the treatment of acne or skin disease for Covered Persons thirty-five (35) years or older, unless Prior Authorization has been obtained.

3. Legend homeopathic drugs.

4. Fertility agents, oral, vaginal and injectable.

5. Allergen injectables.

6. Over-the-counter equivalents and non-legend medications (OTC), except as specifically covered.

7. Medical office administered medications.

8, Durable Medical Equipment.*

9. Experimental or Investigational drugs.

10. Abortifacient drugs.

11. Weight management.

12. COVID-19 home tests.

*Eligible for coverage under the Medical Benefits, subject to all provisions and limitations of this Plan.

MEDICAL BENEFIT DETERMINATION REQUIREMENTS

ELIGIBLE SERVICES, TREATMENTS AND SUPPLIES

Services, treatments or supplies are eligible for coverage if they meet all of the following requirements:

1. They are administered, ordered or provided by a Physician or other eligible Licensed Health Care Provider; and

2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury or they are specifically included as a benefit if not Medically Necessary; and

3. Charges do not exceed the Usual, Customary and Reasonable limits of the Plan; and

4. They are not excluded under any provision or section of this Plan.

Treatments, services or supplies excluded by this Plan may be reimbursable if such charges are approved by the Plan Administrator prior to beginning such treatment. Prior approval is limited to medically accepted non-experimental or investigational treatments, services, or supplies, which, in the opinion of the Plan Administrator, are more cost effective than a covered treatment, service or supply for the same Illness or Injury, and which benefit the Covered Person.

DEDUCTIBLE

The Deductible is stated in the Schedule of Medical Benefits according to the applicable Reward Levels as indicated in the Schedules of Benefits. The Deductible applies to Expenses Incurred during each Benefit Period, unless specifically waived, but it applies only once for each Covered Person within a Benefit Period. Also, if members of a Family have satisfied individual Deductible amounts that collectively equal the Deductible per Family, as stated in the Schedule of Medical Benefits, during the same Benefit Period, no further Deductible will apply to any member of that Family during that Benefit Period. **An individual Covered Person cannot receive credit toward the Family Deductible for more than the Individual Deductible as stated in the Schedule of Medical Benefits.**

BENEFIT PERCENTAGE

The Benefit Percentage is stated in the Schedule of Medical Benefits according to the applicable Reward Level. The Plan will pay the Benefit Percentage of the Eligible Expense indicated.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum, per Covered Person or Family, whichever is applicable, is stated in the Schedule of Medical Benefits and includes the Deductible, amounts in excess of the Benefit Percentage paid by the Plan and any applicable Medical Benefit Copayments. Expenses Incurred in a single Benefit Period after satisfaction of the Out-of-Pocket Maximum per Covered Person or per Family, whichever is applicable, will be paid at 100% of the Eligible Expense for the remainder of the Benefit Period. **An individual Covered Person cannot receive credit toward the Family Out-of-Pocket Maximum for more than the Individual Out-of-Pocket Maximum as stated in the Schedule of Medical Benefits.**

COPAYMENT

Copayments are stated in the Schedule of Medical Benefits according to the applicable Reward Levels as indicated in the Schedules of Benefits. A Copayment is the portion of the medical expense that is the responsibility of the Covered Person. A Copayment is applied for each occurrence of such covered medical service and will apply toward the Out-of-Pocket Maximum and after the Out-of-Pocket Maximum is satisfied, Copayments will no longer apply for the remainder of the Benefit Period.

MAXIMUM BENEFIT

The amount payable by the Plan will not exceed any Maximum Benefit or Maximum Lifetime Benefit as stated in the Schedule of Medical Benefits, for any reason.

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

Deductibles will be applied to Expenses Incurred in the chronological order in which they are adjudicated by the Plan. Expenses Incurred will be paid by the Plan in the chronological order in which they are adjudicated by the Plan. The manner in which the Deductible is applied and Expenses Incurred are paid by the Plan will be conclusive and binding on all Covered Persons and their assignees.

CHANGES IN COVERAGE CLASSIFICATION

A change in coverage that decreases a benefit of this Plan will become effective on the stated effective date of such change with regard to all Covered Persons to whom it applies.

NEW YORK STATE EXPENSES

This Plan has voluntarily elected to make public goods payments directly to the Office of Pool Administration in conformance with HCRA provisions and New York State Department of Health (Department) requirements.

MEDICAL BENEFITS

The following Medical Benefits are payable as stated in the Schedule of Medical Benefits subject to any benefit maximums specifically stated in the Schedule and all terms and conditions of this Plan.

1. **Acupuncture:** Acupuncture performed by a licensed Health Care Provider will be payable as stated and limited in the Schedule of Benefits.

2. **Alcoholism and/or Chemical Dependency:** Coverage under this benefit includes the following services:

   A. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary treatment, including but not limited to group therapy.

   B. Well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.

   C. Inpatient or partial hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.

   D. Medically Necessary treatment, including aftercare, at an Alcoholism and/or Chemical Dependency Treatment Facility or Residential Treatment Facility for Alcoholism and/or Chemical Dependency and licensed as such by the State in which the facility operates that is primarily for the treatment of Alcoholism and/or Chemical Dependency if it meets these requirements:

      1) Has a Physician in regular attendance;
      2) Continuously provides twenty-four (24) hour a day nursing service on site or on call by a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
      3) Has a full-time Psychiatrist or Psychologist on staff;
      4) Is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Alcoholism and/or Chemical Dependency; and
      5) ASAM level 3.3 or higher criteria.

   Medically Necessary will not include Maintenance Therapy which means medical and non-medical health-related services that does not seek to cure, or that which are provided during periods when the medical condition of the patient is not changing, or does not require continued administration by medical personnel.

   Notification is required for admission to a Residential Treatment Facility. **Please refer to the Notification Provisions of this Plan for further details.**

3. **Allergy Services:** Allergy testing, treatment and serum. Allergy injections will be payable under the Physician's Office Visit benefit.

4. **Ambulance Service:** Commercial or ground or air ambulance service to the nearest facility where Emergency care or treatment can be rendered; or from one facility to another for care; or from a facility to the patient's home when Medically Necessary.

5. **Ambulatory Surgical Center:** Services and supplies provided by an Ambulatory Surgical Center.

6. **Anesthetics/Oxygen:** The cost and administration of an anesthetic or for oxygen and other gases and their administration.

7. **Aquatic Therapy:** Medically Necessary aquatic or pool therapies.

8. **Autism Spectrum Disorder:** Testing and treatment for Autism Spectrum Disorder is covered the same as any other Illness or Injury, including treatment for ABA (Applied Behavioral Analysis) therapy.

9. **Bariatric Surgery:** Medically Necessary surgical treatment and follow-up care for Morbid Obesity/Clinically Severe Obesity, including complications, only if pre-approved. See Bariatric Program for further details.

10. **Birthing Center:** Services and supplies furnished by a Birthing Center.

11. **Blood and Blood Derivatives:** Blood transfusions, blood processing, blood transporting, blood handling, administration, and the cost of blood, plasma and blood derivatives. Any credit allowable for replacement of blood plasma by donor or blood insurance will be deducted from the total Eligible Expense.

12. **Bone Density Testing:** Medically Necessary diagnosis and treatment of osteoporosis for high-risk individuals who: a) are estrogen deficient and at clinical risk for osteoporosis, b) have vetebral abnormalities; c) are receiving long term glucocorticoid (steroid) therapy; d) have primary hyperparathyroidism; or e) have a family history of osteoporosis.

13. **Cardiac Rehabilitation:** Cardiac Rehabilitation services which are rendered: a) under the supervision of a Physician; and b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; and c) in a medical care facility.

    Expenses in connection with Phase III cardiac rehabilitation including, but not limited to, Occupational Therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made, and exercise therapy that no longer requires the supervision of medical professionals.

14. **Chiropractic Care/Spinal Manipulation:** Skeletal adjustments, manipulation, or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays will be payable as shown in the Schedule of Benefits.

15. **Circumcision:** Services and supplies related to circumcision.

16. **Cleft Lip and/or Cleft Palate:** Cleft lip and cleft palate treatment, including medical, dental, Speech Therapy, audiology and nutrition services, but only if they are prescribed by the treating Physician or surgeon and the Physician or surgeon certifies that the services are Medically Necessary.

17. **Contraceptive Management:** Contraceptive Management, regardless of Medical Necessity. “Contraceptive Management” means Physician fees related to a prescriptive contraceptive device, obtaining a prescription for contraceptives, purchasing, fitting, injecting, implantation or placement of any contraceptive device or removal regardless of Medical Necessity. Contraceptive supplies or devices available without a Physician’s prescription or contraceptives provided over-the-counter are only covered as outlined in the Pharmacy Benefit section.

18. **Dental Care:**

    A. Dental services and x-rays rendered by a Dentist or Dental Surgeon for the treatment of a fractured jaw or Accidental Injury to sound natural teeth. Such expenses must be Incurred within twelve (12) months of the date of accident except in the event that it is medically impossible for service to be completed within that time frame because of the age of the Covered Person or because of the healing process of the Injury.

B. General anesthesia and hospitalization services in assuring the safe delivery of necessary dental care provided to a Covered Person of any age who:

1) Is determined by a licensed Dentist and the attending Physician to require necessary dental treatment in a Hospital or Ambulatory Surgical Center because of a significantly complex dental condition or a developmental disability in which patient management has proved ineffective; or
2) Has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Dental services due to Illness or Injury will be payable as shown in the Schedule of Benefits, subject to review by the Plan. A letter of Medical Necessity from the attending Physician and the Dentist's treatment plan must be submitted to the Plan Supervisor before charges will be considered.

This Plan will be primary for any charges covered under this Plan that may also be covered under a Dental Plan sponsored by the Employer.

19. **Diabetic Supplies:** Diabetic supplies, other than those that are specifically covered under the Pharmacy Benefit, for the treatment of gestational, Type I or Type II diabetes. Custom made diabetic shoes when Medically Necessary and prescribed by a Physician. Diabetic supplies are eligible for coverage under the Pharmacy Benefit of this Plan including; syringes, needles, swabs, blood test strips, blood glucose calibration solutions, urine tests, lancets and lancet devices.

20. **Diabetic Treatment**: Treatment of Diabetes, including Medically Necessary and appropriate equipment, supplies and services used to treat diabetes, and Outpatient self-management training and educational services.

21. **Diagnostic Testing, X-ray and Laboratory Services:** Diagnostic testing, x-ray and laboratory tests, including electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, CAT scans, MRIs, microscopic tests, or similar well-established diagnostic tests generally accepted by Physicians throughout the United States.

22. **Durable Medical Equipment:** The rental of a wheelchair, Hospital bed, respirator or other Durable Medical Equipment required for therapeutic use will be payable as shown in the Schedule of Benefits, subject to the following:

A. The equipment must be prescribed by a Physician and needed in the treatment of an Illness or Injury;

B. The equipment will be provided on a rental basis, or the purchase of this equipment if economically justified, whichever is less. If there is a known medical reason to rent rather than purchase Durable Medical Equipment, rental then renal is allowed up to the purchase price. Any amount paid to rent the equipment will be applied towards the purchase price. In no event will the rental cost of Durable Medical Equipment exceed the purchase price of the item;

C. Benefits will be limited to standard models, as determined by the Plan;

D. The Plan will pay for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless Medically Necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan;

E. If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered; and

F. Expenses for the rental or purchase of any type of air conditioner, air purifier, or any other device or appliance will not be considered eligible.

23. **Emergency Room Services:** Treatment in a Hospital emergency room, including professional services will be payable as shown in the Schedule of Benefits.

24. **Eyeglasses and Lenses for Medical Purposes:** Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary surgical procedure to the eye, aphakic patients, or soft lenses or sclera shells intended for use as corneal bandages, or contact lenses to treat a keratoconus diagnosis.

25. **Gender Identity Disorder/Gender Dysphoria Services:** The Medically Necessary surgical and non-surgical treatment such as:

A. Psychotherapy;

B. Continuous hormone replacement therapy and corresponding testing to monitor the safety; and

C. Surgical treatment.

Expenses for treatment of Gender Identity Disorder are covered to the same extent as would be covered if the same covered service was rendered for another medical condition. Treatment is subject to all Plan Provisions including applicable Deductibles, Copayments and Benefit Percentage.

Certain services are excluded from coverage under the Medical Benefits Exclusion section of the Plan. It is important to review those exclusions.

26. **Genetic Testing:** Expenses for genetic testing procedures only if Medically Necessary or as specifically covered under the Preventive Care Benefit.

27. **Hearing Aids:** Hearing aids and their fittings will be payable as shown in the Schedule of Benefits, regardless of Medical Necessity. Charges for batteries are excluded.

28. **Hemodialysis/Peritoneal Dialysis:** Treatment of a kidney disorder by hemodialysis or peritoneal dialysis as an Inpatient in a Hospital or other facility, or for expense in an Outpatient facility or in the Covered Person's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaced Inpatient or Outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person's home as shown under the Durable Medical Equipment benefit.

29. **Hinge Health:** Charges are payable as specifically stated in the Schedule of Benefits. Coverage under this benefit includes musculoskeletal disease management through Hinge Health telehealth services (Telemedicine) for Employees and Dependents age eighteen (18) and older only.

30. **Home Health Care:** Services provided by a Home Health Care Agency to a Covered Person in the home will be payable as shown in the Schedule of Benefits. The following are considered eligible home health care services in accordance with a Home Health Care Plan for the following services:

    A. Part-time or intermittent nursing care by a Registered Nurse (RN) or by a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN), or public health nurse who is under the direct supervision of a Registered Nurse;

    B. Home health aides;

    C. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital.

    Home Health Care specifically excludes the following:

    A. Services and supplies not included in the approved Home Health Care Plan.

    B. Services of a person who ordinarily resides in the home of the Covered Person, or who is a Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

    C. Services of any social worker.

    D. Transportation services.

    E. Housekeeping services.

    F. Custodial Care.

31. **Home and Outpatient Infusion Services:** Home and Outpatient infusion services ordered by a Physician and provided by a Home and Outpatient Infusion Therapy Organization licensed and approved within the state in which the services are provided. Home and Outpatient infusion therapy services include the preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Covered Person by a Home and Outpatient Infusion Therapy Organization. Services also include education for the Covered Person, the Covered Person's care giver, or a family member. Home and Outpatient infusion therapy services include pharmacy, supplies, equipment and skilled nursing services when billed by a Home and Outpatient Infusion Therapy Organization.

    Skilled nursing services billed by a Home Health Care Agency are covered under the Home Health Care Benefit.

    A "Home and Outpatient Infusion Therapy Organization" is a health care facility that provides home and Outpatient infusion therapy services and skilled nursing services.

32. **Hospice Care:** Services provided by a Hospice within any one Hospice Benefit Period will be payable as shown in the Schedule of Benefits. The following are considered eligible Hospice services:

    A. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services.

    B. Nursing care by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN), a public health nurse who is under the direct supervision of a Registered Nurse.

    C. Medical supplies, including drugs and biologicals and the use of medical appliances.

D. Physician's services.

E. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.

F. Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.

G. Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family. (The bereavement services must be furnished within six (6) months after the patient's death and payable up to limits shown in Schedule of Benefits.

The term "Patient's Immediate Family" as used herein means the patient's spouse, parents, and/or Dependent children who are covered under the Plan.

33. **Hospital Services or Long-Term Acute Care Facility/Hospital:** The following are considered eligible charges payable as shown in the Schedule of Benefits:

A. Daily Room and Board and general nursing services, or confinement in an Intensive Care Unit.

B. Medically Necessary Hospital Miscellaneous Expenses other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and emergency room use, Physical Therapy treatments, hemodialysis, and x-ray.

C. Nursery neonatal units, general nursing services, including Hospital Miscellaneous Expenses for services and supplies, Physical Therapy, hemodialysis and x-ray, care or treatment of Injury or Illness, congenital defects, birth abnormalities or premature delivery incurred by a Newborn Dependent.

D. Therapy which has been prescribed by a speech pathologist or Physician and includes a written treatment plan with estimated length of time for therapy.

34. **Massage Therapy or Rolfing:** Massage therapy or rolfing for a medical condition, only if services are performed by a licensed provider, payable as shown in the Schedule of Benefits.

35. **Maternity/Pregnancy:** Expenses Incurred by the covered Employee or a Dependent Spouse for Pregnancy, including prenatal care, childbirth, miscarriage, and any medical complications arising out of or resulting from Pregnancy. Expenses for Amniocentesis testing and Cystic fibrosis testing will also be eligible. Elective induced abortions are eligible only when carrying the fetus to full term would seriously endanger the life of the mother. If complications arise after the performance of any abortion, any Expenses Incurred to treat those complications will be eligible, whether the abortion was eligible or not. Coverage for well woman prenatal visits as a required recommended preventive service are covered under the Preventive Care Benefit. However, abortion services in any jurisdiction where the service is illegal by the law of that jurisdiction are excluded regardless.

36. **Medical and Surgical Supplies:** Dressings, sutures, casts, splints, trusses, crutches, braces, custom-made orthotics, and other Medically Necessary supplies ordered by a Physician. Foot orthotics are covered under the Podiatry benefit.

37. **Medical Records:** Reasonable charges for producing medical records only if incurred for the purpose of utilization review, audits or investigating a claim for benefits if requested and approved by the Plan. Charges that exceed limits for such charges imposed by applicable law will not be deemed to be reasonable.

38. **Mental Illness:** The following are considered eligible Mental Illness services and are payable as shown in the Schedule of Benefits:

    A. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary Psychiatric Care and treatment including, but not limited to group therapy.

    B. Well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.

    C. Outpatient behavioral health treatment, including individual therapy, group therapy or family therapy, medication management, or any combination of the four (4) types of treatment.

    D. Inpatient and partial hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.

    E. Medically Necessary treatment, including involuntary or court ordered admissions, at a Psychiatric Facility or Residential Treatment Facility for Mental Illness and licensed as such by the State in which the facility operates that is primarily for the treatment of Mental Illness if it meets these requirements:

        1) Has a Physician in regular attendance;
        2) Continuously provides twenty-four (24) hour a day nursing service on site or on call by a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
        3) Has a full-time Psychiatrist or Psychologist on staff;
        4) Is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Mental Illness; and
        5) ASAM level 3.3 or higher criteria.

    Medically Necessary will not include Maintenance Therapy which means medical and non-medical health-related services that does not seek to cure, or that which are provided during periods when the medical condition of the patient is not changing, or does not require continued administration by medical personnel.

    Notification is required for admission to a Residential Treatment Facility. **Please refer to the Notification Provisions of this Plan for further details.**

39. **Midwife Services:** Services by a Certified Nurse Midwife (CNM) who is a Registered Nurse and enrolled in either the certification maintenance program or the continuing competency assessment program through the American College of Nurse Midwives (ACNM).

    Services of a direct-entry midwife or lay midwife or the practice of direct-entry midwifery will not be considered eligible. A Direct-entry midwife is one practicing midwifery and licensed pursuant to the state in which services are performed and who is not a licensed Certified Nurse Midwife.

40. **Newborn Care:** Newborn care, including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the newborn's expense.

    If the Newborn is ill, suffers an Injury, or requires care other than routine care, benefits will be provided on the same basis as any other Eligible Expense.

41. **Nutritional Supplements:** Physician prescribed nutritional supplements or other enteral supplementation necessary to sustain life, including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation. Special dietary treatment for phenylketonuria (PKU) when prescribed by a Physician.

    Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

42. **Occupational Therapy:** Occupational Therapy rendered by an occupational therapist on an Outpatient basis under the recommendation of a Physician whose primary purpose is to provide medical care for an Illness or Injury. Expenses for Maintenance Therapy, or therapy primarily for recreational or social interaction will not be considered eligible.

43. **Organ and Tissue Transplant Procedures:** Services and supplies in connection with non-Experimental or non-Investigational organ or tissue transplant procedures, subject to the following conditions:

    A. A second opinion is recommended prior to undergoing any transplant procedure. This second opinion should concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

    B. If the donor is covered under this Plan, Expenses Incurred by the donor will be considered for benefits to the extent that such expenses are not payable by the recipient's plan.

    C. If the recipient is covered under this Plan, Expenses Incurred by the recipient will be considered for benefits. If the donor is not covered under this Plan, reference provision E.

    D. If both the donor and the recipient are covered under this Plan, Expenses Incurred by each person will be treated separately for each person.

    E. The Eligible Expense of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology, and pathology fees for the removal of the organ, and a Hospital's charge for storage or transportation of the organ, will be considered eligible. In no event will benefits be payable in excess of the applicable benefit limits still available to the recipient.

44. **Orthognathic Surgery:** Orthognathic surgery and related charges. Any orthodontic expenses related to orthognathic surgery will not be considered eligible.

45. **Orthopedic Appliance:** Purchase of Orthopedic Appliances or replacement or repair of Orthopedic Appliances.

46. **Outpatient Renal Dialysis:** Outpatient renal dialysis will be payable up to the limits stated in the Schedule of Medical Benefits. In order to avoid or reduce liability for amounts not covered by the Plan, a Covered Person who is diagnosed with End Stage Renal Disease (ESRD) should immediately follow these steps:

    A. Notify Plan Administrator when diagnosed with ESRD by the attending Physician;

    B. Notify Plan Administrator if or when beginning dialysis treatments; and

    C. Enroll in Parts A and B of Medicare; and

    D. Contact Specialty Care Management at (765) 320-0118.

47. **Physical Therapy:** Physical Therapy rendered by an physical therapist on an Outpatient basis under the recommendation of a Physician whose primary purpose is to provide medical care for an Illness or Injury. Expenses for Maintenance Therapy, or therapy primarily for recreational or social interaction will not be considered eligible.

48. **Physician Services:** Services of a licensed Physician or Licensed Health Care Provider for medical care and/or treatments, including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations will be payable as shown in the Schedule of Benefits.

    Diagnostic x-ray and laboratory services which are ordered on the same day as the office visit, but performed or read at a later date and/or at another facility will be considered as part of the office visit.

    Charges are eligible for drugs intended for use in a Physicians' office or settings other than home use that are billed during the course of an evaluation or management encounter.

    For Out-of-Network Providers, when two or more Surgical Procedures occur during the same operative session, charges will be considered as follows:

    A. When multiple or bilateral Surgical Procedures are performed that increase the time and amount of patient care, 100% of the Eligible Expense will be considered for the Major Procedure; and 50% of the Eligible Expense will be considered for each of the lesser procedures, except for contracted or negotiated services. Contracted or negotiated services will be reimbursed at the contracted or negotiated rate.

    B. When an incidental procedure is performed through the same incision, only the Eligible Expense for the Major Procedure will be considered. Examples of incidental procedures are: excision of a scar, appendectomy at the time of other abdominal surgery, lysis of adhesions, etc.

    When an assisting Physician or non-physician is required to render technical assistance during a Surgical Procedure, the charges for such services will be limited to 20% of the primary surgeon's Eligible Expense for the Surgical Procedure.

    For In-Network Providers payment will be made pursuant to the provider contract.

49. **Preventive/Prophylactic Mastectomy or Oophorectomy:** Coverage includes charges for a preventive/prophylactic mastectomy or oophorectomy regardless of Medical Necessity for treatment of individuals at high risk of developing breast cancer when any ONE of the following criteria is met:

    Individuals with a personal history of cancer as noted below:

    1. Individuals with a personal history of breast cancer when any ONE of the following criteria is met:

        A. Diagnosed at age forty-five (45) or younger;

        B. Diagnosed at age fifty (50) or younger with at least one close blood relative* with breast cancer at any age;

        C. Diagnosed with two breast primaries (includes bilateral disease or cases where there are two or more clearly separate ipsilateral primary tumors) when the first breast cancer diagnosis occurred prior to age fifty (50);

        D. Diagnosed at age sixty (60) or younger with a triple negative breast cancer;

        E. Diagnosed at age fifty (50) or younger with a limited family history (e.g., fewer than two first- or second degree female relatives or female relatives surviving beyond forty-five (45) years in the relevant maternal and/or paternal lineage);

        F. Diagnosed at any age and there are at least two close blood relatives* with breast cancer diagnosed at any age;

G. Diagnosed at any age and there is at least one close blood relative* with breast cancer at age fifty (50) or younger;

H. Diagnosed at any age and there are at least two close blood relatives* with pancreatic cancer or prostate cancer (Gleason score ≥7) at any age;

I. Diagnosed at any age with one or more close blood relatives* with epithelial ovarian cancer, fallopian tube, or primary peritoneal cancer;

J. Close male blood relative* with breast cancer;

K. An individual of Ashkenazi Jewish descent;

L. Development of invasive lobular or ductal carcinoma in the contralateral breast after electing surveillance for lobular carcinoma in situ of the ipsilateral breast;

M. Lobular carcinoma in situ confirmed on biopsy;

N. Lobular carcinoma in situ in the contralateral breast;

O. Diffuse indeterminate microcalcifications or dense tissue in the contralateral breast that is difficult to evaluate mammographically and clinically;

P. A large and/or ptotic, dense, disproportionately-sized contralateral breast that is difficult to reasonably match the ipsilateral cancerous breast treated with mastectomy and reconstruction.

2. Personal history of epithelial ovarian, fallopian tube, or primary peritoneal cancer;

3. Personal history of pancreatic cancer or prostate cancer (Gleason score ≥7) at any age with two or more close blood relatives* with breast, ovarian, pancreatic cancer, or prostate cancer (Gleason score ≥7) at any age;

4. Personal history of pancreatic cancer at any age with Ashkenazi Jewish ancestry and one or more close blood relatives* with breast, ovarian, pancreatic cancer, or prostate cancer (Gleason score ≥7) at any age;

5. Personal history of male breast cancer.

Individuals with no personal history of breast or epithelial ovarian cancer when any ONE of the following is met:

1. Known breast risk cancer antigen (BRCA1 or BRCA2), or PTEN mutation confirmed by genetic testing;

2. Close blood relative* with a known BRCA1, BRCA2 or PTEN mutation;

3. First- or second-degree blood relative* meeting any of the above criteria for individuals with a personal history of cancer;

4. Third-degree blood relative with breast and/or epithelial ovarian/fallopian tube/primary peritoneal cancer with two or more close blood relatives* with breast and/or ovarian cancer (with at least one close blood relative with breast cancer prior to age fifty (50);

5. History of treatment with thoracic radiation;

6. Atypical ductal or lobular hyperplasia, especially if combined with a family history of breast cancer;

7. Dense, fibronodular breasts that are mammographically or clinically difficult to evaluate, several prior breast biopsies for clinical and/or mammographic abnormalities, and strong concern about breast cancer risk.

*A close blood relative/close family member includes first- , second-, and third-degree relatives on the same side of the family.

A first-degree relative is defined as a blood relative with whom an individual shares approximately 50% of his/her genes, including the individual's parents, full siblings, and children.

A second-degree relative is defined as a blood relative with whom an individual shares approximately 25% of his/her genes, including the individual's grandparents, grandchildren, aunts, uncles, nephews, nieces and half-siblings.

A third-degree relative is defined as a blood relative with whom an individual shares approximately 12.5% of his/her genes, including the individual's great-grandparents and first-cousins.

50. **Podiatry:** Treatment for the following foot conditions: a) weak, unstable or flat feet; b) bunions, when an open cutting operation is performed; c) non-routine treatment of corns or calluses; d) toenails when at least part of the nail root is removed or Medically Necessary by diagnosis (i.e. PVD); e) any Medically Necessary surgical procedure required for a foot condition; or f) custom-made orthotics, including orthopedic shoes when an integral part of a leg brace.

51. **Pre-admission Testing:** Outpatient pre-admission testing performed within seven (7) days prior to a scheduled Inpatient Hospitalization or surgery.

52. **Prescription Drugs:** Drugs requiring the written prescription of a Physician or a Licensed Health Care Provider and Medically Necessary for the treatment of an Illness or Injury. Coverage also includes prescription contraceptive drugs not available through the Pharmacy Benefit regardless of Medical Necessity and FDA approved over-the-counter female contraceptives prescribed by a Physician or Licensed Health Care Provider.

Conditions of coverage for Outpatient prescription drugs and supplies available through the Pharmacy Benefit are as stated in the Pharmacy Benefit section of the Plan.

53. **Preventive Care:** The following are eligible Preventive Care Services:

A. Routine Wellness care for children and adults for the following:

1) Routine physical examinations by a Physician or Licensed Health Care Provider, which will include a medical history, physical examination, developmental assessment, and anticipatory guidance as directed by a Physician or Licensed Health Care Provider and associated routine testing provided or ordered at the time of the examination; and
2) Routine immunizations according to the schedule of immunizations which is recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention.

B. Prostate Specific Antigen (PSA) test for men or Digital Rectal Exams (DRE) for men starting at age forty (40).

C. Recommended preventive services as set forth in the recommendations of the United States Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines supported by the Health Resources and Services Administration. The complete list of recommendations and guidelines can be viewed at: https://www.healthcare.gov/coverage/preventive-care-benefits/.

D. Office visit charges only if the primary purpose of the office visit is to obtain a recommended Preventive Care service identified above.

E. Women's Preventive Care for the following:

1) Well-women annual visits for women 18 years of age and older to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care, and additional visits as medically appropriate.

2) Screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

3) Human papillomavirus (HPV) DNA testing.

4) Annual counseling on sexually transmitted infections (STI) and human immune-deficiency virus (HIV) screening for all sexually active women.

5) All Food and Drug Administration approved prescription contraceptives and female over-the-counter contraceptives when prescribed by a Physician or Licensed Health Care Provider, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs. Self-administered contraceptives are available only through the Pharmacy Benefit as outlined in the Pharmacy Benefit section of this Plan.

6) Breast feeding support, supplies, and counseling, including comprehensive lactation support and counseling by a trained provider during Pregnancy and/or in the postpartum period, and costs for breast feeding equipment and related supplies.

7) Annual screening and counseling for interpersonal and domestic violence.

Expenses payable under this Preventive Care Benefit will not be subject to the Medical Necessity provisions of this Plan. Charges for Preventive Care that involve excessive, unnecessary or duplicate tests are specifically excluded.

Charges for treatment of an active Illness or Injury are subject to the Plan Provisions, limitations and exclusions and are not eligible in any manner under Preventive Care.

54. **Private Duty Nursing:** Service of a Registered Nurses (RNs), Licensed Vocational Nurses (LVNs) or Licensed Practical Nurses (LPNs) for private duty nursing. Special duty nursing services are excluded as follows:

A. Which would ordinarily be provided by the Hospital staff or its Intensive Care Unit (the Hospital benefit of the Plan pays for general nursing services by Hospital staff); or

B. When private duty nurse is employed solely for the convenience of the patient or the patient's Family or for services which would consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication or acting as a companion, sitter or when otherwise deemed not Medically Necessary as requiring skilled nursing care.

55. **Prosthetic Appliance:** Artificial limbs, eyes, larynx, or other Prosthetic Appliance for replacement when necessary due to an Illness or Injury. Charges for the repair or replacement will only be included as an Eligible Expense when required due to a pathological change or replacement is less expensive than repair of existing equipment. Replacement due to normal wear and tear and deterioration is not considered eligible.

56. **Radiation Therapy/Chemotherapy:** Radium and radioactive isotope therapy, and chemotherapy treatment will be payable as shown in the Schedule of Benefits.

57. **Reconstructive Breast Surgery:** Reconstructive breast surgery subsequent to any Medically Necessary mastectomy or preventive/prophylactic mastectomy covered under this Plan, limited to the following:

A. Reconstruction of the breast(s) upon which the mastectomy was performed, including implants;

B. Surgical procedures and reconstruction of the non-affected breast to produce a symmetrical appearance, including implants;

C. Non-surgical treatment of lymphedemas and other physical complications of mastectomy, including non-surgical prostheses and implants for producing symmetry.

Specifically excluded from this benefit are expenses for the following:

A. Solely Cosmetic procedures unrelated to producing a symmetrical appearance;

B. Breast augmentation procedures unrelated to producing a symmetrical appearance;

C. Implants for the non-affected breast unrelated to producing a symmetrical appearance;

D. Non-surgical prostheses or any other procedure unrelated to producing a symmetrical appearance.

58. **Rehabilitation Facility:** Inpatient care provided in a Rehabilitation Facility will be payable as shown in the Schedule of Benefits, provided such confinement a) is under the recommendation and general supervision of a Physician; b) begins after discharge from a required Hospital or Skilled Nursing Facility confinement; c) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Care confinement; and d) is not for Custodial Care.

See the Skilled Nursing Care benefit for services and supplies provided for confinements in a Skilled Nursing Facility.

59. **Routine Patient Costs:** Routine Patient Costs for a Phase I Approved Clinical Trial for Qualified Individuals.

Routine Patient Costs include but are limited to Medically Necessary services which a Covered Person with the identical diagnosis and current condition would receive even in the absence of participating in an Approved Clinical Trial.

Routine Patient Costs do not include any investigational item, device, or service that is part of the Approved Clinical Trial; an item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient; a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or an item or service customarily provided and paid for by the sponsor of an Approved Clinical Trial.

"Approved Clinical Trial" means a Phase I clinical trial that is conducted in relation to the prevention, detection, or treatment of an acutely life-threatening disease state and is not designed exclusively to test toxicity or disease pathophysiology. The Approved Clinical Trial must be:

A. Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;

B. Exempt from obtaining an investigational new drug application; or

C. Approved or funded by:

1) The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the entities described above;
2) A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
3) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or
4) The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to:

a) Be comparable to the system of peer review of studies and investigations used by the national institutes of health; and
b) Provide unbiased scientific review by individuals who have no interest in the outcome of the review.

A Qualified Individual is a Covered Person who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of an acutely life-threatening disease state and either (i) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate, or (ii) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

60. **Routine Qualifier Services:** The following qualifier services will be payable as shown in the Schedule of Benefits and as shown below for Covered Employees and spouses only:

Plan Qualifiers	Paid 100% by Plan	Qualifier Guidelines
Lab Draw	Must be completed by all Employees / Spouses to qualify for Select or Premium Reward Level	Odd year - spouses Even year - Employees
Pap Smear, Mammogram	Must be completed according to age guidelines to qualify for the Premium Reward Level	Age 20, 25, 30, 35, 40, 43, 46, 50 & over

Skin Screening	Must be completed according to age guidelines to qualify for the Premium Reward Level	Age 20, 25, 30, 35, 40, 43, 46, 50 & over
Testicular Exam	Must be completed according to age guidelines to qualify for the Premium Reward Level	Age 20, 25, 30, 35, 40, 43, 46, 50 & over
Colonoscopy	Must be completed according to age guidelines to qualify for the Premium Reward Level	Age 50 and every 10 years thereafter **Note that if newly covered Employees and spouse age 50 and older, first colonoscopy is covered under the qualifiers regardless of age. After initial then will follow above age requirements.

61. **Scalp Hair Prosthesis:** Purchase of a scalp hair prosthesis when necessitated by hair loss due to the medical condition known as alopecia areata, or as the result of hair loss due to radiation or chemotherapy for diagnosed cancer will be payable as shown in the Schedule of Benefits.

62. **Skilled Nursing Facility:** Charges made by a Skilled Nursing Facility for the following services and supplies furnished by the facility during convalescent confinement. Only charges in connection with convalescence from the Illness or Injury for which the Covered Person was Hospital-confined will be eligible for benefits. These expenses include:

    A. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services.

    B. Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physicians' fees.

    C. Drugs, biologicals, solutions, dressings and casts, furnished for use during the convalescent confinement, but no other supplies.

63. **Sleep Disorders:** Treatment of or related to sleep disorders.

64. **Speech Therapy:** Services provided by a licensed speech therapist for Speech Therapy, also called speech pathology, and audio diagnostic testing services for diagnosis and treatment of speech and language disorders.

65. **Sterilization:** Vasectomies. Sterilization procedures for women are covered under the Preventive Care Benefit.

66. **Telemedicine Consultation:** Services that are related to or as a result of Telemedicine, but limited to the following methods:

    A. An interactive patient encounter between the Physician or Licensed Health Care Provider being consulted and the patient. This method requires a “live” two way video and audio transmission between the patient and the Physician or Licensed Health Care Provider, and may include one additional provider who is presenting the patient to a specialist for an opinion regarding the patient’s condition.

    B. Storing and forwarding medical documentation to a licensed Radiologist or Pathologist for the purpose of reviewing telecommunicated medical documentation at a time which is convenient to the Radiologist or Pathologist’s schedule. This method does not require actual contact between the patient and the provider.

Expenses billed for the use of equipment or transmission charges to transmit the audiovisual information are not covered.

Telemedicine does not include charges for teleconsultations, which involves a practitioner seeking advice from a consultant concerning a patient's condition or course of treatment.

67. **Temporomandibular Joint Dysfunction (TMJ):** Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).

    The treatment of jaw joint disorders (TMJ) includes conditions of structures linking the jawbone and skull and complex muscles, nerves, and other tissues related to the temporomandibular joint. Treatment includes, but is not limited to: orthodontics; physical therapy; and any appliance that is attached to or rests on the teeth.

68. **Testosterone Injections:** Medically Necessary expenses for testosterone injections and related office visit.

69. **Tobacco Cessation:** Tobacco cessation programs only when referred by the Med Center are payable as shown in the Schedule of Benefits. This includes but is not limited to the following: a) one-on-one visits with clinician, include electrical simulation on the ears; b) one-on-one visit with a certified dietician; c) educational materials; and d) cessation products (prescription and over-the-counter gums, patches, etc.

70. **Urgent Care Facility:** Services and supplies provided by an Urgent Care Facility will be payable as shown in the Schedule of Benefits.

71. **Weight Loss Program:** The program must be under the supervision of a licensed Physician. Patient must have a diagnosis of Morbid Obesity or Clinically Severe Obesity. Eligible Expenses include Physician office visits and services provided by the weight loss clinics, such as medications, supplements, injections, blood-pressure monitoring and dietary counseling.

BARIATRIC PROGRAM

A Covered Person must enroll in the Bariatric Program and actively participate for twelve (12) consecutive months in the Bariatric Program prior to consideration for pre-certification of any gastric by-pass surgery and six (6) consecutive months following the surgery. Surgery must be performed immediately after completing the twelve (12) month program. Recommendation regarding request for gastric procedures limited to: Bariatric Surgery, Gastric Stapling, Laparoscopic Gastric Bypass, Roux-en-Y Gastric Bypass (RYGB), or other medical policy standard technique.

The following criteria will be used for pre-certifying benefits for the above procedures:

1. A clinical history of unsuccessful diet and other weight management programs.

2. Must receive a positive assessment of surgery risk-benefit from all evaluating staff members of the pre-surgery program.

3. Must be at least 18 years of age and less than 70 years of age.

The following is specifically excluded:

1. Surgical procedures except for Bariatric Surgery, Gastric Stapling, Roux-En-Y Divided Bypass Surgery or other medical policy standard technique.

2. Any Expenses Incurred for which all of the conditions of the Bariatric Program have not been met.

3. Any redo or revision of a prior bariatric surgical procedure, unless the indication for surgery is to treat or manage a diagnosis or condition unrelated to further weight loss.

4. A second bariatric surgical procedure, whether or not the first procedure was performed while covered under this Plan or not.

Please contact The MedCenter for further information. (239) 252-4257.

MEDICAL EXPENSE AUDIT BONUS

The Plan offers an incentive to all Covered Persons to encourage examination and self-auditing of eligible medical bills to ensure the amounts billed by any provider accurately reflect the services and supplies received by the Covered Person. The Covered Person is asked to review all medical charges and verify that each itemized service has been received and that the bill does not represent either an overcharge or a charge for services never received. This self-auditing procedure is strictly voluntary; however, it is to the advantage of the Plan as well as the Covered Person to avoid unnecessary payment of health care costs.

In the event a self-audit results in elimination or reduction of benefits paid, 50% of the amount saved will be reimbursed directly to the Participant (subject to $10 minimum payment and a $500 maximum payment per Calendar Year), provided the savings are accurately documented, and satisfactory evidence is submitted to the Plan Supervisor (e.g. a copy of the incorrect bill and a copy of the corrected billing).

This self-audit credit is in addition to the payment of all other applicable Plan benefits for legitimate medical expenses.

This credit will not be payable for expenses in excess of the Usual, Customary and Reasonable charges which are not covered under the Plan, regardless of whether benefits paid are reduced.

NOTIFICATION PROVISIONS
Community Health Partners
(239) 659-7770 or (888)-594-9008

To ensure the most appropriate care is provided, and to control the costs of this Plan, the Plan contains a notification provision. The notification provision requires that a Covered Person call Community Health Partners (CHP) **at least twenty-four (24) hours before:**

1. All elective (non-urgent, pre-arranged, non-emergency) Inpatient admissions in a Hospital, Hospice, Skilled Nursing, Rehabilitation or Chemical Dependency/Mental Illness Treatment Facilities. If an Emergency admission or procedure, CHP must be notified within forty-eight (48) hours following the admission or procedure.

2. Any of the following that are done on an Outpatient basis: CAT Scans, MRI, MRA, CT Guided procedures.

3. All transplants, including initial consultation, evaluation, and actual transplant.

4. Rental or purchase of Durable Medical Equipment (DME) with cost anticipated in excess of $500.00.

5. When an Observation Stay is greater than twenty-four (24) hours (greater than one midnight) or converts to an Inpatient admission.

   "Observation Stay" is an alternative to an Inpatient admission that allows reasonable and necessary time to evaluate and render Medically Necessary services to a patient whose diagnosis and treatment are not expected to exceed twenty-four (24) hours but may extend to forty-eight (48) hours, and the need for an Inpatient admission can be determined within this specific period. An Inpatient admission is generally appropriate when the patient is expected to need two (2) or more midnights of Medically Necessary Hospital care.

6. Home Health care in excess of five (5) visits for skilled nursing visits, home Physical, Occupational and Speech Therapy.

Pre-notification is not required for virtual colonoscopies or if any one of these procedures is performed in the emergency room.

For a non-emergency hospitalization, CHP will evaluate the proposed admission plan and length of stay. CHP will certify the number of days appropriate. In making these determinations, the diagnosis, physical status and any other complicating conditions of the patient will be taken into account. CHP will review any x-ray and laboratory results and confer with the attending Physician if necessary. The decision to be admitted will always rest with the patient and the Physician. The notification process will let the patient know, before expenses are incurred, whether or not the admission would be certified. Benefits will only be available for the number of days that have been certified. If the confinement will last longer than the number of days certified, CHP must be notified. At this point, CHP will conduct a Continued Stay Review. The Continued Stay Review will be conducted in much the same way as the initial notification. The case will be reviewed with the attending Physician to determine any additional Inpatient days. Benefits will not be available for any days beyond those certified.

If a Covered Person is admitted to the Hospital or other facility or receives one of the listed Outpatient procedures on an Emergency basis, the Covered Person must call CHP **within forty-eight (48) hours following** the admission, test, or procedure. If Emergency admission occurs on a weekend or holiday, notification can be extended to the first business day following the Emergency admission.

Notification can come from the Covered Person, the Hospital, or the Physician. **However, the Covered Person is ultimately responsible for the notification.** It is strongly recommended, therefore, that the Covered Person makes the call.

Notification requires only a brief phone call to CHP at (239) 659-7770 or toll free at (888) 594-9008. If the call is made after hours, the following information must be left on CHP's confidential voice mail:

- Employee's name.
- Employee ID number.
- Patient's name and relationship to the Employee.
- The name of the Hospital where the procedure will take place (if applicable).
- The procedure to be performed.
- The name and telephone number of the Physician.

It is vital the call occurs within the time frames list above. **If notification is not made, Eligible Expenses will be reduced by $300 per procedure or confinement except for Urgent Care claims as stated in the Procedures for Claiming Benefits section.**

If notification is not provided within the times outlined, CHP will review the claim to determine whether the admission, test, or procedure was Medically Necessary. Irrespective of the eventual determination by CHP, the penalty will still be applied and cannot be rescinded.

Hospital stays in connection with childbirth for either the mother or Newborn may not be less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to notify CHP of the maternity admission, unless the stay extends past the applicable forty-eight (48) or ninety-six (96) hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the Newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

If the patient is unconscious, in a coma or unable to contact CHP due to Illness or Injury rendering the patient physically or mentally incapable, the notification requirement will be waived until the patient is able to contact CHP. Certification will be retroactive to the date of admission.

ONCOLOGY PRE-TREATMENT REVIEW

For oncology claims only, Pre-treatment Review is strongly recommended. To obtain Pre-Treatment Review for oncology claims, please follow the procedure outlined below.

1. ONCOLOGY MEDICAL MANAGEMENT PROGRAM: CARE INTEGRATION

   In order to initiate oncology management services, the Covered Person's oncologist should contact the Plan Supervisor at (800) 877-1122 to verify Plan benefits. At that time, the oncologist will be asked to contact StarPoint at (877) 791-7827 and to provide a copy of the treatment plan that oncologist has prescribed for the Covered Person (including chemotherapy and radiation provided in any setting). StarPoint will remain in contact with the Covered Person and the oncologist for the duration of the treatment plan through recovery and transitional care. Please call (877) 791-7827 for questions regarding cancer care, side affects and other quality of life issues.

   In order to receive benefit payments under the Plan, the oncologist's oncology plan of treatment must be received by StarPoint, and deemed not to be Experimental and/or Investigational as described below. The Plan may not pay for or otherwise cover the cost of oncology related treatment considered Experimental and/or Investigational as defined by the Plan.

   Unless the oncologist has entered into an agreement with StarPoint to accept other reimbursement rates, the payment for all drugs used in the treatment of cancer will be limited to the rate of Average Sales Price plus 10%. Average Sales Price is updated quarterly by Medicare.

2. EXPERIMENTAL AND/OR INVESTIGATIONAL

   The Plan may not pay for or otherwise cover the cost of oncology related treatment considered Experimental and/or Investigational. For purposes of oncology drugs only, Experimental and or Investigational is defined as:

   In the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigational where (1) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs Compendium, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints or clinical Pharmacology or (2) the drug is provided in association with a Phase III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute ("NCI") or (3) the drug is provided in association with a Phase II trial for cancer by an NCI-sponsored group and standard treatment has been or would be ineffective or does not exist or there is no clearly superior non-investigational alternative that can be delivered more cost efficiently as determined by the Plan Administrator.

MANDATORY CASE MANAGEMENT

Community Health Partners (CHP) will monitor a Covered Person's emerging risk, a condition or diagnosis that may be potentially significant by utilizing several different methods such as Verisk Medical Intelligence, Notification request, Pharmacy and TPA reports.

When a Covered Person has been identified with emerging risk they will be encouraged to enroll in case management and actively participate in their care plan. Active participation is described as, communicating with their case manager on a weekly basis until less intensity is needed determined by the case Manager or the Covered Person is disenrolled from program. Communication may be in the form of letters, phone calls, face to face meetings or encrypted emails. If a Covered Person cancels an appointment with the case manager, it is the Covered Person's responsibility to reschedule with 48 business hours. If a Covered Person refuses to participate and their level of medical and pharmacy spend combined exceeds $100,000 in a six (6) month period, they will receive a monetary benefit adjustment for failure to participate.

First Contact: Covered Persons will be contacted by a case manager as soon as a trend is identified to enroll the Covered Person into case management. Initially a letter will be sent from Community Health Partners advising the Covered Person they have been identified to participate in case management and will be contacted within one week. The letter will provide the case manager's contact information and ask the Covered Person to be pro-active and reach out to the case manager and communicate the best time to schedule a call with the Covered Person.

Second Contact: If no-response, the case manager will confirm with the Human Resource Department that they have the most current contact information. A second call will be place within 48 business hours.

Third Contact: Third call will be place to the Covered Person within another 48 business hour cycle. This call will be placed after normal business hours between 5 and 7pm.

Fourth contact: Certified letter requiring a signature will be sent to the Covered Person's current home address. This letter will outline the attempts made to contact the Covered Person as well as the potential benefit adjustment due to failure to participate.

While participation in case management is voluntary, declining to participate or declining to continue to participate in case management services when requested by the Plan will result in an additional Copayment of $1,000 for non-participation of the condition for which case management was declined. The additional Copayment imposed by this provision will not accrue towards the Out-of-Pocket Maximum or change after satisfaction of the annual Out-of-Pocket Maximum.

GENERAL EXCLUSIONS AND LIMITATIONS

The General Plan Exclusions and Limitations of the Plan apply to Medical Benefits in addition to the following Medical Benefit Exclusions:

1. **Abortions:** Expenses related to elective abortions, except as specified under the Maternity benefit under **Medical Benefits**. However, abortion services in any jurisdiction where the service is illegal by the law of that jurisdiction are excluded regardless.

2. **Acupuncture:** Acupuncture except as specified under Medical Benefits.

3. **Adoption:** Expenses for adoption will not be considered eligible.

4. **Against Medical Advice:** Complications that directly result from acting against medical advice, non-compliance with specific Physician's orders or leaving an Inpatient facility against medical advice will not be considered eligible.

5. **Artificial Organ:** Expenses for insertion or maintenance of artificial organ implant procedures.

6. **Biofeedback:** Expenses for biofeedback will not be considered eligible, unless pre-determined for Medical Necessity.

7. **Cardiac Rehabilitation:** Expenses in connection with Phase III cardiac rehabilitation including, but not limited to, occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made, and exercise therapy that no longer requires the supervision of medical professionals.

8. **Chelation Therapy:** Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning. Chelation therapy reduces the plaque deposits in the arteries and other parts of the body.

9. **Close Relative:** Services rendered by a Physician or Licensed Health Care Provider who is a Close Relative of the Covered Person, or resides in the same household of the Covered Person and who does not regularly charge the Covered Person for services.

10. **Complications:** Expenses for care, services or treatment required as a result of complications from a treatment not covered under the Plan will not be considered eligible or that are the result of any medical complication resulting from a treatment, service or supply which is, or was at the time the charge was incurred, excluded from coverage under this Plan will not be considered eligible. This exclusion does not apply to complications from abortions as specified under Medical Benefits.

11. **Convalescent Care:** Expenses for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations, tests or treatments not connected with the actual Illness or Injury will not be considered eligible.

12. **Convenience/Personal Comfort:** Services or supplies used primarily for Cosmetic, personal comfort, convenience, hygiene, beautification items, television or telephone use that are not related to treatment of a medical condition.

13. **Cosmetic:** Expenses in connection with the care or treatment of, surgery performed for, or as the result of, a Cosmetic procedure. **This exclusion will not apply when such treatment is rendered to correct a condition resulting from an Accidental Injury or an Illness, or when rendered to correct a congenital anomaly.**

14. **Counseling:** Expenses for recreational counseling or milieu therapy.

15. **COVID-19:** Charges for COVD-19 home tests.

16. **Custodial Care:** Expenses related to Custodial Care will not be considered eligible.

17. **Dental Care:** Expenses Incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified under Medical Benefits.

18. **Developmental Delays:** Expenses in connection with the treatment of developmental delays including, but not limited to, Speech Therapy, Occupational Therapy, Physical Therapy, and any related diagnostic testing will not be considered eligible. This exclusion does not apply to any Autism Spectrum Disorder.

19. **Education or Training:** Expenses for professional services on an Outpatient basis in connection with disorders of any type or cause, that can be credited towards earning a degree or furtherance of the education or training of a Covered Person regardless of the diagnosis will not be considered eligible.

20. **Examinations:** Charges for examinations for employment, licensing, insurance, school, camp, sports or adoption purposes.

21. **Experimental/Investigational:** Expenses for services, supplies or treatments or procedures, surgical or otherwise which are Experimental or Investigational, except for treatment for ABA (Applied Behavioral Analysis) therapy.

22. **Foot Care:** Expenses for routine foot care will not be considered eligible for the following services:

    A. Cutting or removal of corns and calluses;

    B. Trimming, cutting, clipping, or debriding of nails;

    C. Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients; and

    D. Any other service performed in the absence of localized Illness, Injury or symptoms involving the foot.

23. **Gambling Addiction:** Expenses for services related to gambling addiction will not be considered eligible.

24. **Gender Dysphoria:** Expenses for voice modification; suction assisted lipoplasty of the waist; blepharoplasty; facial reconstruction or facial feminization surgery; hair removal or other non-Medically Necessary services, care or treatment of Gender Identity Disorder or Gender Dysphoria.

    Treatment of Gender Identity Disorder/Gender Dysphoria when the services are for reversal of a prior gender reassignment surgery or reversal of a prior surgery to revise secondary sex characteristics.

25. **Governmental Agency:** Expenses for services or supplies which are obtained from any governmental agency without cost by compliance with laws or regulations enacted by any governmental body. Also, charges to the extent that the Covered Person could have obtained payment, in whole or in part, if he or she had applied for coverage or obtained treatment under any federal, state or other governmental program or in a treatment facility operated by a government agency, except where required by law, such as for cases of medical emergencies or for coverage provided by Medicaid are not considered eligible.

26. **Hair Loss:** Expenses for hair transplant procedures, wigs and artificial hairpieces or drugs which are prescribed to promote hair growth or remove hair, except as specified under Medical Benefits.

27. **Homeopathic Treatment:** Expenses for homeopathic, naturopathic and holistic medical procedures will not be eligible.

28. **Human Subject Study:** Expenses which are performed subject to the Covered Person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study experiment will not be considered eligible.

29. **Hypnotherapy:** Expenses for hypnotherapy will not be considered eligible.

30. **Illegal Charges:** Expenses for services, treatment or supplies not considered legal in the United States.

31. **Incarceration:** Charges for care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

32. **Incurred by a Non-Covered Person:** Expenses Incurred by persons other than the Covered Person receiving treatment or Expenses for treatment, services or supplies not actually rendered to or received and used by the Covered Person will not be considered eligible.

33. **Infertility:** Expenses related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or in-vitro fertilization, or any other assisted reproductive technique.

34. **Mailing:** Expenses for mailing and/or shipping and handling expenses will not be considered eligible.

35. **Maintenance Therapy:** Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

36. **Maternity/Pregnancy:** Expenses for maternity Expenses Incurred by a Dependent other than an Employee's spouse will not be considered eligible. This exclusion does not include well woman prenatal visits as a required recommended preventive service as specifically covered under the Preventive Care Benefit.

37. **Medically Necessary:** Expenses for services, supplies or treatments or procedures, surgical or otherwise, not recognized as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury.

38. **Missed Appointments/Not Rendered In Physical Presence:** Expenses for completion of claim forms, missed appointments, telephone consultations, or for treatment which is not rendered by or in the physical presence of a Physician or Licensed Health Care Provider, expedited processing fees, shipping and handling feels will not be considered eligible. This exclusion does not apply to on-site clinic telephone assessment and management services when billed by the on-site Licensed Mental Health Counselor at Collier County Government or Telemedicine.

39. **No Legal Obligation:** Expenses for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

40. **Non-Medical Expenses:** Expenses for non-medical expenses such as training, education, instructions or educational materials, even if they are performed, provided or prescribed by a Physician are not considered eligible, except as specified under Medical Benefits.

41. **Non-Prescription:** Supplies or devices available without a Physician's prescription, except as covered under the Preventive Care Benefit.

42. **Not Performed Under the Direction of a Physician:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

43. **Nutritional Supplements:** Expenses for non-prescription vitamins or nutritional supplements, except as covered under the Preventive Care Benefit.

44. **Obesity:** Expenses in connection with services or supplies provided for the treatment of obesity and weight reduction, except as specified for Bariatric Surgery under Medical Benefits or as specified under the Weight Loss Program.

45. **Other Plan:** Any services or supplies to the extent that benefits are otherwise provided under this Plan, or under any other plan of group benefits that the Participant's Employer contributes to or sponsors.

46. **Prior to Effective Date:** Expenses for services rendered or started, or supplies furnished prior to the effective date of coverage under the Plan, or after coverage is terminated under the Plan, except as specifically provided for in the Plan Provisions.

47. **Refractive Errors:** Expenses for any surgical, medical or Hospital services and/or supplies rendered in connection with radial keratotomy, LASIK or any other procedure designed to correct farsightedness, nearsightedness or astigmatism.

48. **Routine Care:** Expenses for routine medical examinations, routine health check-ups or preventive immunizations not necessary for the treatment of an Injury or Illness, except as specified under Medical Benefits.

49. **Sales Tax:** Expenses for sales tax will not be considered eligible.

50. **Sexual dysfunction:** Expenses for any services, care or treatment for sexual dysfunction including medications, surgery, medical, counseling or Psychiatric Care or treatment will not be considered eligible, except as specified under Medical Benefits.

51. **Stand-by Physician:** Expenses for technical medical assistance or stand-by Physician services will not be considered eligible.

52. **Sterilization:** Expenses resulting from or in connection with the reversal of an elective sterilization procedure.

53. **Surrogate:** Expenses related to surrogate services of a non-covered person will not be considered eligible. Non-covered persons are not eligible for coverage under this Plan.

54. **Tobacco Cessation:** Expenses for tobacco cessation programs, including tobacco deterrents not incurred thru The MedCenter will not be considered eligible except as specified under the Health Plan Qualifiers section and as specifically listed as an Eligible Expense. See Medical Benefits.

55. **Travel:** Expenses Incurred for travel by any person for any reason will not be considered eligible.

56. **Useful to Persons in Absence of Illness or Injury:** Expenses for services, treatments or supplies that may be useful to persons in the absence of Illness or Injury such as air conditioners, purifiers, humidifiers, special furniture, bicycles, whirlpools, dehumidifiers, exercise equipment, health club memberships, etc., concierge provider subscription fees (monthly or annually), or any other membership or subscription fees, whether or not they have been prescribed or recommended by a Physician.

57. **Usual, Customary and Reasonable:** Expenses in excess of the Usual, Customary and Reasonable limits of the Plan will not be considered eligible.

58. **Vision Care:** Expenses in connection with eye refractions, the purchase or fitting of eyeglasses or contact lenses, except as specifically listed as a covered expense in the Eyeglasses and Lenses for Medical Purposes benefit.

59. **War:** Expenses which are caused by or arising out of war or act of war, (whether declared or undeclared), civil unrest, armed invasion or aggression, or caused during service in the armed forces of any country.

60. **Work Related:** Expenses Incurred by the Covered Person for all services and supplies resulting from any Illness or Injury which occurs in the course of employment for wage or profit, or in the course of any volunteer work when the organization, for whom the Covered Person is volunteering, has elected or is required by law to obtain coverage for such volunteer work under state or federal workers' compensation laws or other legislation, including Employees' compensation or liability laws of the United States (collectively called "Workers' Compensation"). This exclusion applies to all such services and supplies resulting from a work-related Illness or Injury even though:

    A. Coverage for the Covered Person under Workers' Compensation provides benefits for only a portion of the services Incurred;

    B. The Covered Person's employer/volunteer organization has failed to obtain such coverage required by law;

    C. The Covered Person waived his/her rights to such coverage or benefits;

    D. The Covered Person fails to file a claim within the filing period allowed by law for such benefits;

    E. The Covered Person fails to comply with any other provision of the law to obtain such coverage or benefits; or

    F. The Covered Person is permitted to elect not to be covered by Workers' Compensation but failed to properly make such election effective.

    G. The Covered Person is permitted to elect not to be covered by Workers' Compensation and has affirmatively made that election.

    This exclusion will not apply to household and domestic employment, employment not in the usual course of the trade, business, profession or occupation of the Covered Person or Employee, or employment of a Dependent member of an Employee's family for whom an exemption may be claimed by the Employee under the Internal Revenue Code, or in cases in which it is legally impossible to obtain Workers' Compensation coverage for a specific Illness or Injury.

    This exclusion also does not apply to the claims of a Covered Person whose workers' compensation coverage has ended specifically because the Covered person has reached Maximum Medical Improvement (MMI) as finally determined and certified without objection or appeal by a workers' compensation fund or insurance carrier.

COORDINATION OF BENEFITS

The Coordination of Benefits provision prevents the payment of benefits which exceed the Allowable Expense. It applies when the Participant or Dependent who is covered by this Plan is or may also be covered by any other plan(s). This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan(s), will not exceed 100% of Allowable Expense. Only the amount paid by this Plan will be charged against the Plan maximums.

In the event of a motor vehicle or premises accident; or an act of violence with the intent to disrupt electronic, communications, or any other business system, this Plan will be secondary to any auto "no-fault" and traditional auto "fault" type contracts, homeowners, commercial general liability insurance and any other medical benefits coverage.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization is hereby given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Plan Document are subject to this provision.

DEFINITIONS

"Allowable Expense" as used herein means:

1. If the claim as applied to the primary Plan is subject to a contracted or negotiated rate, Allowable Expense will be equal to that contracted or negotiated amount.

2. If the claim as applied to the primary Plan is not subject to a contracted or negotiated rate, but the claim as applied to the secondary Plan is subject to a contracted or negotiated rate, the Allowable Expense will be equal to that contracted or negotiated amount of the secondary Plan.

3. If the claim as applied to the primary Plan and the secondary Plan is not subject to a contracted or negotiated rate, then the Allowable Expense will be equal to the secondary Plan's chosen limits for non-contracted providers.

"Plan" as used herein means any Plan providing benefits or services for or by reason of medical, dental or vision treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis including, but not limited to:

   A. Hospital indemnity benefits; and

   B. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims; or

2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans; or

3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision; or

4. A licensed Health Maintenance Organization (HMO); or

5. Any coverage for students which is sponsored by, or provided through a school or other educational institution; or

6. Any coverage under a governmental program, and any coverage required or provided by any statute; or

7. Automobile insurance; or

8. Individual automobile insurance coverage on an automobile leased or owned by the Company or any responsible third-party tortfeasor; or

9. Individual automobile insurance coverage based upon the principles of “no-fault” coverage; or

10. Homeowner or premise liability insurance, individual or commercial.

“Plan” will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

ORDER OF BENEFIT DETERMINATION

1. **Non-Dependent/Dependent**

   The Plan that covers the person as other than a dependent, (e.g., as an employee, member, subscriber, retiree) is primary and the Plan that covers the person as a dependent is secondary.

2. **Dependent Child Covered Under More Than One Plan**

   Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      1) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      2) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

   B. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      1) If a court decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child’s health care expenses, but that parent’s spouse does, that parent’s spouse’s plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;
      2) If a court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of subparagraph A of this paragraph shall determine the order of benefit;
      3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph A of this paragraph shall determine the order of benefit;
      4) If there is no court decree allocating responsibility for the child’s health care expenses or health care coverage, the order of benefits for the child are as follows:

         a) The plan covering the custodial parent;

b) The plan covering the custodial parent's spouse;
c) The plan covering the non-custodial parent; and then
d) The plan covering the non-custodial parent's spouse.

C. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a or b of this paragraph as if those individuals were parents of the child.

D. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph 5 applies.

E. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the order of benefits shall be determined by applying the birthday rule in subparagraph A to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-Off Employee**

A. The plan that covers a person as an active employee that is an employee who is neither laid-off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

B. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. This rule does not apply if the rule in paragraph 1 can determine the order of benefits.

4. **COBRA or State Continuation Coverage:**

A. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering the same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. This rule does not apply if the rule in paragraph 1 can determine the order of benefits.

5. **Longer or Shorter Length of Coverage**

A. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

B. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the Covered Person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.

C. The start of a new plan does not include:

1) A change in the amount or scope of a plan's benefits;
2) A change in the entity that pays, provides or administers the plan's benefits; or
3) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

D. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

6. If none of these preceding rules determines the order of benefits, the Allowable Expense shall be shared equally between the Plans.

COORDINATION WITH MEDICARE

Medicare Part A or Part B will be considered a Plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare whether or not the Covered Person is actually receiving Medicare Benefits. This means that the Plan will only pay the amount that Medicare would not have covered, even if the Covered Person does not elect to be covered under Medicare. Also, failure to enroll in Medicare Part B or Part D when a person is initially eligible may result in the person being assessed a significant surcharge by Medicare for late enrollment in Part B or Part D.

1. **For Working Aged**

A covered Employee who is eligible for Medicare Part A or Part B as a result of age may be covered under this Plan and be covered under Medicare, in which case this Plan will pay primary. A covered Employee, eligible for Medicare Part A or Part B as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan will terminate.

A covered Dependent, eligible for Medicare Part A or Part B as a result of age, of a covered Employee may also be covered under this Plan and be covered under Medicare, in which case the Plan again will pay primary. A covered Dependent, eligible for Medicare Part A or Part B as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan will terminate.

2. **For Retired Persons**

Medicare is primary and the Plan will be secondary for the covered Retiree if he/she is an individual who is enrolled in Medicare Part A or Part B as a result of age or disability and retired.

Medicare is primary and the Plan will be secondary for the covered Retiree's Dependent who is enrolled in Medicare Part A or B if both the covered Retiree and his/her covered Dependent are enrolled in Medicare Part A or Part B as a result of age or disability and retired.

Medicare is primary for the Retiree's Dependent when the Retiree is not enrolled for Medicare Part A or Part B as a result of age and the Retiree's Dependent is enrolled in Medicare Part A or Part B as a result of age or disability.

3. **For Covered Persons who are Disabled**

The Plan is primary and Medicare will be secondary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability, if the Employee is actively employed by the Employer.

The Plan is secondary and Medicare will be primary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability if the Employee is retired or otherwise not actively working for the Employer.

4. **For Covered Persons with End Stage Renal Disease**

Except as stated below*, for Employees or Retirees and their Dependents, if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), this Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, this Plan will be secondary with respect to Medicare coverage, unless after the thirty-month period described above, the Covered Person has no dialysis for a period of twelve (12) consecutive months and:

A. Then resumes dialysis, at which time the Plan will again become primary for a period of thirty (30) months; or

B. The Covered Person undergoes a kidney transplant, at which time the Plan will again become primary for a period of thirty (30) months.

*If a Covered Person is covered by Medicare as a result of disability, and Medicare is primary for that reason on the date the Covered Person becomes eligible for Medicare as a result of End Stage Renal Disease, Medicare will continue to be primary and the Plan will be secondary.

COORDINATION WITH MEDICAID

If a Covered Person is also entitled to and covered by Medicaid, the Plan will always be primary and Medicaid will always be secondary coverage.

COORDINATION WITH TRICARE/CHAMPVA

If a Covered Person is also entitled to and covered under TRICARE/CHAMPVA, the Plan will always be primary and TRICARE/CHAMPVA will always be secondary coverage. TRICARE coverage will include programs established under its authority, known as TRICARE Standard, TRICARE Extra and TRICARE Prime.

If the Covered Person is eligible for Medicare and entitled to veterans benefits through the Department of Veterans Affairs (VA), the Plan will always be primary and the VA will always be secondary for non-service connected medical claims. For these claims, the Plan will make payment to the VA as though the Plan was making payment secondary to Medicare.

PROCEDURES FOR CLAIMING BENEFITS

Claims must be submitted to the Plan within twelve (12) months after the date services or treatments are received or completed. Non-electronic claims may be submitted on any approved claim form, available from the provider. The claim must be completed in full with all the requested information. A complete claim must include the following information:

- Date of service;
- Name of the Participant;
- Name and date of birth of the patient receiving the treatment or service and his/her relationship to the Participant;
- Diagnosis [code] of the condition being treated;
- Treatment or service [code] performed;
- Amount charged by the provider for the treatment or service; and
- Sufficient documentation, in the sole determination of the Plan Administrator, to support the Medical Necessity of the treatment or service being provided and sufficient to enable the Plan Supervisor to adjudicate the claim pursuant to the terms and conditions of the Plan.

When completed, the claim must be sent to the Plan Supervisor, Allegiance Benefit Plan Management, Inc., at P.O. Box 3018, Missoula, Montana 59806-3018, (406) 721-2222 or (800) 877-1122 or through any electronic claims submission system or clearinghouse to which Allegiance Benefit Plan Management, Inc. has access.

A claim will not, under any circumstances, be considered for payment of benefits if initially submitted to the Plan more than twelve (12) months from the date that services were incurred.

Upon termination of the Plan, final claims must be received within three (3) months of the date of termination, unless otherwise established by the Plan Administrator.

CLAIMS WILL NOT BE DEEMED SUBMITTED UNTIL RECEIVED BY THE PLAN SUPERVISOR.

The Plan will have the right, in its sole discretion and at its own expense, to require a claimant to undergo a medical examination, when and as often as may be reasonable, and to require the claimant to submit, or cause to be submitted, any and all medical and other relevant records it deems necessary to properly adjudicate the claim.

CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY

Claims will be considered for payment according to the Plan's terms and conditions, industry-standard claims processing guidelines and administrative practices not inconsistent with the terms of the Plan. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims that involve specialized medical knowledge or judgment. Initial eligibility and claims decisions will be made within the time periods stated below. For purposes of this section, "Covered Person" will include the claimant and the claimant's Authorized Representative; "Covered Person" does not include a health care provider or other assignee, and said health care provider or assignee does not have an independent right to appeal an Adverse Benefit Determination simply by virtue of the assignment of benefits.

"Authorized Representative" means a representative authorized by the claimant to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize this Authorized Representative when the Plan receives the written authorization.

INFORMATION REGARDING URGENT CARE CLAIMS IS PROVIDED UNDER THE DISCLOSURE REQUIREMENTS OF APPLICABLE LAW; THE PLAN DOES NOT MAKE TREATMENT DECISIONS. ANY DECISION TO RECEIVE TREATMENT MUST BE MADE BETWEEN THE PATIENT AND HIS OR HER HEALTHCARE PROVIDER; HOWEVER, THE PLAN WILL ONLY PAY BENEFITS ACCORDING TO THE TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THIS PLAN.

1. **Urgent Care Claims** - An Urgent Care Claim is any claim for medical care or treatment with respect to which:

   A. In the judgment of a prudent layperson possessing an average knowledge of health and medicine could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

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

   There are no Urgent Care requirements under this Plan and therefore, there are no rights to appeal a pre-service Urgent Care Claim denial.

2. **Pre-Service Claims** - Pre-Service Claims must be submitted to the Plan before the Covered Person receives medical treatment or service. A Pre-Service Claim is any claim for a medical benefit which the Plan terms condition the Covered Person's receipt of the benefit, in whole or in part, on approval of the benefit before obtaining treatment. Pre-Service Claims are procedures stated in the Plan Document which, the Plan recommends be utilized before a Covered Person obtains medical care.

3. **Post-Service Claims** - A Post-Service Claim is any claim for a medical benefit under the Plan with respect to which the terms of the Plan do not condition the Covered Person's receipt of the benefit, or any part thereof, on approval of the benefit prior to obtaining medical care, and for which medical treatment has been obtained prior to submission of the claim(s).

   In most cases, initial claims decisions on Post-Service Claims will be made within thirty (30) days of the Plan's receipt of the claim. The Plan will provide timely notice of the initial determination once sufficient information is received to make an initial determination, but no later than thirty (30) days after receiving the claim.

4. **Concurrent Care Review** - For patients who face early termination or reduction of benefits for a course of treatment previously certified by the Plan, a decision by the Plan to reduce or terminate benefits for ongoing care is considered an Adverse Benefit Determination. (Note: Exhaustion of the Plan's benefit maximums is not an Adverse Benefit Determination.) The Plan will notify the Covered Person sufficiently in advance to allow an appeal for uninterrupted continuing care before the benefit is reduced or terminated. Any request to extend an Urgent Care course of treatment beyond the initially prescribed period of time must be decided within twenty-four (24) hours of the Plan's receipt of the request. The appeal for ongoing care or treatment must be made to the Plan at least twenty-four (24) hours prior to the expiration of the initially-prescribed period.

5. **Claims for Payment Disputes for Non-Network Emergency Air Ambulance, Emergency Use of an Emergency Room and Non-Network Physicians and Licensed Health Care Providers While Providing Services Over Which the Covered Person Has No Control -** For providers in this category, the Plan will pay an amount equal to the Median network fee for the same service in the same geographic area. Once payment is made by the Plan, the provider will have thirty (30) days from the date of payment to contact the Plan Supervisor and attempt to negotiate a different payment amount. Failure to contact the Plan Supervisor within such thirty (30) days will result in the amount paid by the Plan being considered payment in full for all purposes. If negotiations are attempted within thirty (30) days but cannot be resolved within that time, the provider may follow the applicable federal or state rules to seek mediation (Independent Dispute Resolution) of the fee amount. The mediators decision shall be binding on the Plan and the provider.

APPEALING AN UN-REIMBURSED PRE-SERVICE CLAIM

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim denial will be provided by the Plan showing:

1. The reason the claim was denied;

2. Reference(s) to the specific Plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;

3. Any additional information needed to perfect the claim and why such information is needed; and

4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Plan Supervisor at the address or telephone number shown on the claim denial.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person must submit in writing an appeal or a request for review of the Adverse Benefit Determination to the Plan within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person should include any additional information supporting the appeal or the information required by the Plan which was not initially provided and forward it to the Plan Supervisor within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations for Pre-Service Claims must be submitted in writing to Community Health Partners, P.O. Box 9529, Naples, FL 34101. Supporting materials may be submitted via facsimile at (239) 659-7799.

Appeals or requests for review of Adverse Benefit Determinations for Post-Service Claims must be submitted to the Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

1. **First Level of Benefit Determination Review**

   The first level of benefit determination review is done by Community Health Partners (CHP). CHP will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within fifteen (15) days following the date CHP receives the request for reconsideration.

   If, based on CHP's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to CHP, not later than sixty (60) days after receipt of CHP's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

2. **Second Level of Benefit Determination Review**

The Plan Administrator will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by the Plan Administrator who is neither the original decision-maker nor the decision-maker's subordinate. The Plan Administrator cannot give deference to the initial benefit determination. The Plan Administrator may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or experimental treatment, the Plan Administrator will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination, which contains the same information as notices for the initial determination, within fifteen (15) days.

If more time or information is needed to make a determination for a pre-service or post-service appeal, the Plan Supervisor will provide notice in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review.

In the event any new or additional information is considered, relied upon or generated in connection with the appeal, the Plan will provide this information to the Covered Person as soon as possible, free of charge and sufficiently in advance of the decision, so that the Covered Person will have an opportunity to respond. Also, if any new or additional rationale is considered for a denial it will be provided to the Covered Person as soon as possible and sufficiently in advance of the decision to allow a reasonable opportunity to respond.

If an appeal decision is not made and issued within the time period described above, or if the Plan fails to meet any of the requirements of this appeal process, the Covered Person may deem the appeal to be exhausted and proceed to the external review or bring a civil action. The Covered Person should contact the Plan Administrator to ask for confirmation that the Covered Person's appeal has been denied, or to request an External Review.

INDEPENDENT EXTERNAL REVIEW FOR A PRE-SERVICE CLAIM

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested for a Pre-Service Claim, CHP will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

If an independent external review is requested for a Post-Service Claim, the Plan Supervisor will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

The IRO will issue a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.

APPEALING AN UN-REIMBURSED POST-SERVICE CLAIM

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim Explanation of Benefits (EOB) will be provided by the Plan showing:

1. The reason the claim was denied;

2. Reference(s) to the specific Plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;

3. Any additional information needed to perfect the claim and why such information is needed; and

4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Plan Supervisor at the address or telephone number shown on the EOB form.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person must submit in writing an appeal or a request for review of the Adverse Benefit Determination to the Plan within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person should include any additional information supporting the appeal or the information required by the Plan which was not initially provided and forward it to the Plan Supervisor within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

1. **First Level of Benefit Determination Review**

   The first level of benefit determination review is done by the Plan Supervisor. The Plan Supervisor will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within thirty (30) days following the date the Plan Supervisor receives the request for reconsideration.

   If, based on the Plan Supervisor's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Plan Supervisor, not later than sixty (60) days after receipt of the Plan Supervisor's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

2. **Second Level of Benefit Determination Review**

The Plan Administrator will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by the Plan Administrator who is neither the original decision-maker nor the decision-maker's subordinate. The Plan Administrator cannot give deference to the initial benefit determination. The Plan Administrator may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or experimental treatment, the Plan Administrator will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination within a reasonable time, but no later than thirty (30) days from the date the appeal is received by the Plan at each level of review.

All claim payments are based upon the terms contained in the Plan Document, on file with the Plan Administrator and the Plan Supervisor. The Covered Person may request, free of charge, more detailed information, names of any medical professionals consulted and copies of relevant documents, as defined in and required by law, which were used by the Plan to adjudicate the claim.

If more time or information is needed to make a determination for a pre-service or post-service appeal, the Plan Supervisor will provide notice in writing to request an extension of up to fifteen (15) days and to specify any additional information needed to complete the review.

In the event any new or additional information is considered, relied upon or generated in connection with the appeal, the Plan will provide this information to the Covered Person as soon as possible, free of charge and sufficiently in advance of the decision, so that the Covered Person will have an opportunity to respond. Also, if any new or additional rationale is considered for a denial it will be provided to the Covered Person as soon as possible and sufficiently in advance of the decision to allow a reasonable opportunity to respond.

If an appeal decision is not made and issued within the time period described above, or if the Plan fails to meet any of the requirements of this appeal process, the Covered Person may deem the appeal to be exhausted and proceed to the external review or bring a civil action. The Covered Person should contact the Plan Administrator to ask for confirmation that the Covered Person's appeal has been denied, or to request an External Review.

INDEPENDENT EXTERNAL REVIEW FOR A POST-SERVICE CLAIM

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested for a Pre-Service Claim, CHP will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

If an independent external review is requested for a Post-Service Claim, the Plan Supervisor will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

The IRO will issue a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.

ELIGIBILITY PROVISIONS

If both spouses are employed by the County, and both are eligible for Dependent Coverage, either spouse, but not both, may elect Dependent Coverage for their eligible Dependents. No one can be covered under this Plan as both an Employee and a Dependent. No one can be covered under this Plan as a Dependent by more than one Participant.

EMPLOYEE ELIGIBILITY

An Employee becomes eligible under this Plan for each classification of Employee as follows:

1. Class I - Is classified as a full-time Employee and is employed by the County on a continuing and regular basis for an average of at least thirty (30) hours per week; or

2. Class II - Is classified as a regular part-time Employee and who is employed by the County on a continuing and regular basis for an average of at least twenty (20) hours per week.

3. Class III - Is employed by the County as a Seasonal Employee as defined by the applicable department's employment manual and PPACA who completes a Measurement Period of twelve (12) consecutive months, during which the Seasonal Employee averages thirty (30) hours per week of actual work and/or paid leave, FMLA leave or jury duty whether paid or not, for twelve (12) consecutive months.

4. Class IV - Is employed by the County as a Paid Intern as defined by the applicable department's employment manual and PPACA who completes a Measurement Period of twelve (12) consecutive months, during which the Paid Intern Employee averages thirty (30) hours per week of actual work and/or paid leave, FMLA leave or jury duty whether paid or not, for twelve (12) consecutive months.

5. Class V - Is employed by the County as a variable hour Employee and completes a Measurement Period of twelve (12) consecutive months, during which the variable hour Employee averages thirty (30) hours per week of actual work and/or paid leave, FMLA leave or jury duty, whether paid or not, for twelve (12) consecutive months.

"Measurement Period" is the period of time adopted by the Plan for Seasonal Employees, Paid Intern Employees or variable hour Employees during which such Employees' work hours and applicable leave are measured to determine whether such Employees are eligible for coverage.

An Employee is not eligible while on active military duty if that duty exceeds a period of thirty-one (31) consecutive days.

Note: As a requirement for enrollment and continued coverage under this Plan, all eligible Dependents of Participants will be required to provide their social security number to the Plan Administrator. This is necessary in order for the Plan Administrator to comply with any and all reporting requirements imposed under federal CMS (Medicare) and IRS guidelines.

WAITING PERIOD

With respect to an eligible Employee, coverage under the Plan will not start until the Employee completes a Waiting Period, which commences on the Enrollment Date (eligibility date) and will be either of the following:

1. Class I or Class II - If the Enrollment Date occurs on the first day of the month, the Waiting Period is waived;

2. Class I or Class II - If the Enrollment Date occurs on any day other than the first day of the month, the Waiting Period will end on the first day of the month following the Enrollment Date; or

3. Class III - For Seasonal Employees, the last day of the month following the end of the Measurement Period defined in "Employee Eligibility" subsection above. If elected, coverage under this section shall continue for a period of not more than twelve (12) months provided the Participant remains employed by the Employer regardless of the number of hours worked during that time period. This period of time is the Coverage Period.

4. Class IV - For Paid Intern Employees, the last day of the month following the end of the Measurement Period defined in "Employee Eligibility" subsection above. If elected, coverage under this section shall continue for a period of not more than twelve (12) months provided the Participant remains employed by the Employer regardless of the number of hours worked during that time period. This period of time is the Coverage Period.

5. Class V - For variable hour Employees, the last day of the month following fifty-nine (59) days from the end of the Measurement Period defined in "Employee Eligibility" subsection above. If elected, coverage under this section shall continue for a period of not more than twelve (12) months provided the Participant remains employed by the Employer regardless of the number of hours worked during that time period. This period of time is the Coverage Period.

DEPENDENT ELIGIBILITY

An eligible Dependent includes any person who is a citizen, resident alien, or is otherwise legally present in the United States or in any other jurisdiction that the related Participant has been assigned by the Employer, and who is either:

1. The Participant's legal spouse according to the marriage laws of the state where the marriage was first solemnized or established.

   An eligible Dependent does not include a spouse who is legally separated or divorced from the Participant and has a court order or decree stating such from a court of competent jurisdiction.

2. The Participant's or Retiree's Dependent child who meets all of the following "Required Eligibility Conditions":

   A. Is a natural child; step-child; legally adopted child; a child who has been Placed For Adoption with the Participant or Retiree and for whom as part of such placement the Participant or Retiree has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Participant or Retiree has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; and

   B. Is less than twenty-six (26) years of age. A Dependent child is eligible until the end of the Calendar Year in which twenty-six (26) years of age is attained. This requirement is waived if the Participant's or Retiree's child is mentally handicapped/challenged or physically handicapped/challenged, provided that the child was incapable of self-supporting employment and was chiefly dependent upon the Participant or Retiree for support and maintenance prior to end of the Calendar month in which he/she attained twenty-six (26) years of age. Proof of incapacity must be furnished to the Plan Administrator upon request, and additional proof may be required from time to time.

EXTENDED-COVERAGE FOR DEPENDENTS

An Extended-Coverage Dependent Child as defined by Florida Statute 627.6562 who is twenty-six (26) years of age but less than thirty (30) years of age may be an eligible Dependent if the Dependent of an eligible Employee under this Plan if the Extended Coverage Dependent child meets all of the following criteria required by Florida Statute:

1. Unmarried without Dependents of their own; and

2. A Florida resident or a full or part-time student; and

3. Not provided coverage under any other health plan or policy; and

4. Not entitled to coverage under Medicare.

The eligible Employee must make an election to continue coverage for the Extended-Coverage Dependent Child, and file an Affidavit of Dependent Eligibility, within thirty-one (31) days following the date such child ceases to satisfy the eligibility requirements for eligible Dependent coverage under the Plan, including certifying that the Extended-Coverage Dependent Child has been continuously covered by other creditable covered (as defined in Section 627.6562, Florida Statutes) without a gap in coverage of more than sixty-three (63) days after the end of the month in which the eligible Extended-Coverage Dependent Child reached age twenty-six (26). Such Extended-Coverage Dependent Child may continue coverage until the last day of the Calendar Year in which the Extended-Coverage Dependent Child attains the age of thirty (30) years of age.

If an eligible Employee fails to make an election to continue coverage under this provision within the time frame or if coverage under this provision terminates, the child will be eligible to make an election to continue coverage in accordance with the COBRA Continuation Coverage section of this Plan.

The eligible Employee or Extended-Coverage Dependent Child is required to pay the entire amount of the cost of coverage for the Extended-Coverage Child under this provision in accordance with the same procedures established under the COBRA Continuation of Coverage section of this Plan.

INTERAGENCY EMPLOYMENT TRANSFERS

In addition to covering Collier County Government Employees, the Plan also covers the following Collier County, Florida Constitutional Officers/public agencies in Collier County, Florida:

1. Clerk of the Circuit Court & Comptroller Collier County, Florida;

2. Supervisor of Elections;

3. Collier County Tax Collector;

4. Collier County Property Appraiser; and

5. Court Administrative Employees (currently categorized within the Collier County Government Employee's group)

In the event that any covered Employee transfers employment under the Plan to another participating Employer, and the commencement of the covered Employee's employment with the other participating Employer commences within four (4) weeks of the covered Employee's separation from the prior participating Employer, the covered Employee and that Employee's Dependents (as the case may be) shall be immediately eligible for coverage under the same enrollment terms, subject to any increase or decrease in the covered Employee's contribution costs for the Plan benefits (i.e., increase/decrease of premium costs based on employer's percentage of assumed cost) resulting from the transfer of employment. Further, the covered Employee's and that Employee's Dependent's use of benefits under the Plan at the time of separation of employment with the prior participating Employer shall carry forward to the new participating employer for the remainder of the current coverage period. All other terms of the Plan shall apply.

PARTICIPANT ELIGIBILITY FOR DEPENDENT COVERAGE

Each Employee will become eligible for Dependent Coverage on the latest of:

1. The date the Employee becomes eligible for Participant coverage; or

2. The date on which the Employee first acquires a Dependent.

RETIREE ELIGIBILITY

An Employee is eligible to continue coverage under this Plan as a Retiree if they are a Qualifying Retiree of Collier County Government. Eligible Dependents of a Qualifying Retiree may also continue coverage under this Plan. Qualifying Retirees must meet the requirements of Florida Statute 112.0801.

EFFECTIVE DATE OF COVERAGE

All coverage under the Plan will commence at 12:01 A.M. in the time zone in which the Covered Person permanently resides, on the date such coverage becomes effective.

PARTICIPANT COVERAGE

Participant coverage under the Plan will become effective on the first day immediately after the Employee satisfies the applicable eligibility requirements and Waiting Period. If these requirements are met, the Employee must be offered coverage or an opportunity to waive coverage even if the offer is after the date coverage should become effective, regardless of the time that has elapsed, provided that the reason coverage was not offered before the end of the Waiting Period was as a result of an administrative error on the part of the Employer, Plan Administrator or Plan Supervisor.

An eligible Employee who declines Participant coverage under the Plan during the Initial Enrollment Period will be able to become covered later in only two situations, Open Enrollment Period and Special Enrollment Period.

If an eligible Employee chooses not to enroll or fails to enroll for coverage under the Plan during the Initial Enrollment Period, coverage for the Employee and Dependents will be deemed waived.

If a Participant chooses not to re-enroll or fails to re-enroll during any Open Enrollment Period, coverage for the Participant and any Dependents covered at the time will remain the same as that elected prior to the Open Enrollment Period.

A Seasonal Employee, Paid Intern or variable hour Employee will remain covered for a period of time not to exceed twelve (12) months from the effective date of coverage (the Coverage Period) regardless of the number of hours worked and applicable leave, as long as the individual remains employed by the County. At the end of the Coverage Period, if the individual remains employed as a Seasonal or Paid Intern and averages at least thirty (30) hours per week during the Coverage Period, the individual will remain covered for a period of time not to exceed an additional twelve (12) months.

“Coverage Period” is the maximum period of time Seasonal Employees, Paid Intern Employees or variable hour Employees can be covered under the Plan as active Employees after completion of a Measurement Period as defined in the “Eligibility Provisions under the “Employee Eligibility” subsection.

DEPENDENT COVERAGE

Each Participant who requests Dependent Coverage on the Plan’s enrollment platform will become covered for Dependent Coverage as follows:

1. On the Participant’s effective date of coverage, if application for Dependent Coverage is made on the same enrollment platform used by the Participant to enroll for coverage. This subsection applies only to Dependents who are eligible on the Participant’s effective date of coverage.

2. In the event a Dependent is acquired after the Participant’s effective date of coverage as a result of a legal guardianship or in the event that a Participant is required to provide coverage as a result of a valid court order, or if the Dependent is acquired as a result of operation of law, Dependent Coverage will begin on the first day of the month following the Plan’s receipt of an enrollment form and copy of said court order, if applicable.

AUTOMATIC NEWBORN COVERAGE

A child born to a covered Employee or covered Dependent spouse is automatically covered for a period of thirty (30) days whether the child is enrolled or not from the moment of birth.

The child must be enrolled in accordance with the terms of the applicable Special Enrollment provisions of this Plan for coverage to continue beyond thirty (30) days.

RETIREE COVERAGE

Coverage for a Qualifying Retiree and eligible Dependents will become effective on the first day of the month following the date of retirement, provided that application for coverage is made on the Plan's enrollment platform with thirty-one (31) days from the last day of the month following the date of retirement.

OPEN ENROLLMENT PERIOD

The Open Enrollment Period will begin November 1 and will end as determined by the Plan Administrator. During any Open Enrollment Period an Employee and the Employee's eligible Dependents, who are not covered under this Plan, may request Participant or Dependent coverage. Coverage must be requested on the Plan's enrollment platform. Also during any Open Enrollment Period, Participants and their covered Dependents will be able to make a change in coverage under this Plan.

Coverage or changes requested during any Open Enrollment Period will begin on January 1 immediately following the Open Enrollment Period and will remain in effect until the next January 1, except as otherwise allowed during a Special Enrollment Period.

SPECIAL ENROLLMENT PERIOD

In addition to other enrollment times allowed by this Plan, certain persons may enroll during the Special Enrollment Periods described below.

Coverage will become effective on the date of the event if the Employee or Retiree makes a special enrollment request, verbally or in writing, within thirty-one (31) days of any special enrollment event and application for such coverage is made on the Plan's enrollment platform within sixty (60) days of the event.

Any eligible Employee or Retiree and any of their eligible Dependents may enroll and become covered as a result of the following specific events:

1. Marriage to the Employee or Retiree; or

2. Birth of the Employee's or Retiree's child; or

3. Adoption of a child by the Employee or Retiree, provided the child is under the age of 19; or

4. Placement for Adoption with the Employee or Retiree , provided such Employee or Retiree has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19; or

5. Coverage under Medicaid or any state children's insurance program recognized under the Children's Health Insurance Program Reauthorization Act of 2009 is terminated due to loss of eligibility; or

6. The date any eligible Employee or Retiree or any of their eligible Dependents becomes entitled to a Premium Assistance Subsidy authorized under the Children's Health Insurance Program Reauthorization Act of 2009. The date of entitlement shall be the date stated in the Premium Assistance Authorization entitlement notice issued by the applicable state agency (CHIP or Medicaid). A request for enrollment, either verbal or in writing, must be made within sixty (60) days after this special enrollment event, and written application for such coverage must be made in writing within ninety (90) days after such event; or

7. Coverage under another health care plan or health insurance is terminated due to loss of eligibility or if employer contributions to the other coverage have been terminated (Loss of Coverage).

Loss of Coverage means only one of the following:

A. COBRA Continuation Coverage under another plan and the maximum period of COBRA Continuation Coverage under that other plan has been exhausted; or

B. Group or insurance health coverage that has been terminated as a result of termination of Employer contributions* towards that other coverage; or

C. Group or insurance health coverage (includes other coverage that is Medicare) that has been terminated only as a result of a loss of eligibility for coverage for any of the following:

1) Legal separation or divorce of the eligible Employee or Retiree;
2) Cessation of Dependent status;
3) Death of the eligible Employee or Retiree;
4) Termination of employment of the eligible Dependent;
5) Reduction in the number of hours of employment of the eligible Dependent;
6) Termination of the eligible Dependent's employer's plan;
7) Any loss of eligibility after a period that is measured by reference to any of the foregoing; or
8) Any loss of eligibility for individual or group coverage because the eligible Employee, Retiree or Dependent no longer resides, lives or works in the service area of the Health Maintenance Organization (HMO) or other such plan.

*Employer contributions include contributions by any current or former employer that was contributing to the other non-COBRA coverage.

A loss of eligibility for coverage does not occur if coverage was terminated due to a failure of the Employee, Retiree or Dependent to pay premiums on a timely basis or coverage was terminated for cause.

For any Special Enrollment event, the Participant may also elect to change coverage options to any coverage option offered by the Plan, subject to any Health Plan Qualifiers. The Coverage Option for the Dependent child must be the same as the Participant.

CHANGE IN STATUS

If a Covered Dependent under this Plan becomes an eligible Employee of the County, he/she may continue his/her coverage as a Dependent or elect to be covered as a Participant.

If an eligible Employee who is covered as a Participant of this Plan ceases to be an Employee of the County, but is eligible to be covered as a Dependent under another Employee/Participant, he/she may elect to continue his/her coverage as a Dependent of such Employee/Participant.

Application for coverage due to a Change in Status must be made on the Plan's enrollment platform, within thirty-one (31) days immediately following the date the Employee becomes or ceases to be an eligible Employee. A Change in Status will not be deemed to be a break or termination of coverage and will not operate to reduce or increase any coverage or accumulations toward satisfaction of the deductible and Out-of-Pocket Maximum to which the Covered Person was entitled prior to the Change in Status.

PERMISSIBLE ENROLLMENT RIGHTS

For the sake of this Plan Document/Summary Plan Description, Open Enrollment Period and Special Enrollment Period shall be understood to be permissible enrollment events as more fully discussed in Permissible Enrollment Changes.

PERMISSIBLE ENROLLMENT CHANGES

An Employee may not make enrollment changes in any way during the Benefit Period except in the case of a Special Enrollment right or the following certain limited circumstances:

1. An Employee may enroll Dependents during a Benefit Period if one of the following changes in status events occurs that results in a gain or loss of eligibility for coverage:

    A. A Change in the Employee's legal marital status.

    B. A change in the Employees number of Dependents.

    C. A change in the employment status (such as termination of employment, a strike or lockout, a commencement or return from an unpaid leave of absence or change in work site) of the Employee or the Employee's Dependent spouse or children which affects his or her eligibility to participate in the Plan or other employee benefit plan of an employer.

    D. A Dependent of the Employee either newly satisfies or ceases to satisfy the eligibility requirements of the Plan.

    E. A change in the legal residence of an Employee, the Employee's Dependent spouse or children which affects his or her eligibility to participate in the Plan.

    F. An order by a court or state child support agency resulting from a divorce, legal separation, annulment or change in custody that requires the Employee to provide health coverage to an Employee's eligible child.

2. An Employee may also be permitted to enroll for coverage due to the following:

    A. The Employee's Dependent spouse or children has a change in coverage under his or her own employer's plan.

    B. The Employee's Dependent experiences a change in eligibility under Medicare, Medicaid or Florida KidCare.

Any requested enrollment change must be on account of and consistent with the change in status. Documentation will be required on all Dependents.

The Employee must change his or her election within thirty (30) days of the event that permits the enrollment change. Any modification or revocation under this shall be effective at such time as the Plan Administrator shall prescribe, but not earlier than the first pay period beginning after the election is submitted to the Plan Administrator. Once the election is submitted, any modification relating to the coverage of additional family members shall be effective retroactively to the date the change in family status occurred.

The Plan Administrator has the discretionary authority to make a determination as to whether an event has occurred permitting a change during the Benefit Period and whether the requested change is on account of and consistent with the rules and regulations of the Internal Revenue Service.

In accordance with the Affordable Care Act's (PPACA) anti-rescission rule, in the absence of lapse of premium, fraud or intentional misrepresentation, retroactive termination of benefits is not allowed. Terminating a Dependent from coverage can only be done prospectively, not retroactively.

Dependent coverage terminates at the end of the month in which the Dependent exercises a change in coverage (i.e., Medicare/Medicaid eligibility, eligibility under their employer's plan or a spouse's plan, termination of coverage per court order, etc.) provided the event allowing a change in coverage occurs within thirty (30) days prior to the date a change in coverage is requested. In the event the Employee does not receive notice of a Permissible Enrollment Event until more than thirty (30) days after such an event, through circumstances beyond the Employee's and Dependent's control, the Dependent may be added or terminated from coverage as applicable at the end of the month in which the Employee received notice if the Employee requests enrollment or termination within thirty (30) days after receipt of such notice. Further, Dependent coverage can be terminated under this section on the date the Permissible Enrollment Event occurs if no premium has been paid for the period after the date of the Permissible Enrollment Event.

Written notice of the Permissible Enrollment Event and supporting documentation must be received by the Third Party Administrator within thirty (30) days after the Permissible Enrollment Event date or within thirty (30) days after the date of late notice, whichever is applicable. If notice and documentation is received after the end of the month in which the Permissible Enrollment Event occurs, but within the thirty (30) days, the termination date will be the end of the month in which the Permissible Enrollment Event occurred.

Premiums cannot be refunded unless it is within the thirty (30) day time frame.

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROVISION

PURPOSE

Although the Collier County Government Employee Benefit Plan is not a Plan covered under ERISA, the Plan Administrator adopts the following procedures, pursuant to Section 609(a) of ERISA, to determine whether Medical Child Support Orders are qualified in accordance with ERISA's requirements, to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required. The County adopts ERISA standards to comply with child support enforcement obligation of Part D of Title IV of the Social Security Act of 1975 as amended.

DEFINITIONS

For QMCSO requirements, the following definitions apply:

1. "Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enroll in this Plan with respect to the Participant.

2. "Medical Child Support Order" means any state or court judgment, decree or order (including approval of settlement agreement) issued by a court of competent jurisdiction, or issued through an administrative process established under State law and which has the same force and effect of law under applicable State law and:

   A. Provides for child support for a child of a Participant under this Plan; or

   B. Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under this Plan; and

   C. Is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.

3. "Plan" means this self-funded Employee Health Benefit Plan, including all supplements and amendments in effect.

4. "Qualified Medical Child Support Order" means a Medical Child Support Order which creates (including assignment of rights) or recognizes an Alternate Recipient's right to receive benefits to which a Participant or Qualified Beneficiary is eligible under this Plan, and has been determined by the Plan Administrator to meet the qualification requirements as outlined under "Procedures for Notifications and Determinations" of this provision.

CRITERIA FOR A QUALIFIED MEDICAL CHILD SUPPORT ORDER

To be qualified, a Medical Child Support Order must clearly:

1. Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient; and

2. Include a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and

3. Specify each period to which such order applies.

In order to be qualified, a Medical Child Support Order must not require the Plan to provide any type or form of benefits, or any option, not otherwise provided under the Plan except to the extent necessary to meet the requirements of Section1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

PROCEDURES FOR NOTIFICATIONS AND DETERMINATIONS

In the case of any Medical Child Support Order received by this Plan:

1. The Plan Administrator will promptly notify the Participant and each Alternate Recipient of the receipt of such order and the Plan's procedures for determining whether Medical Child Support Orders are qualified orders; and

2. Within a reasonable period after receipt of such order, the Plan Administrator will determine whether such order is a Qualified Medical Child Support Order and notify the Participant and each Alternate Recipient of such determination.

NATIONAL MEDICAL SUPPORT NOTICE

If the Plan Administrator of a group health plan which is maintained by the employer of a non-custodial parent of a child, or to which such an employer contributes, receives an appropriately completed National Medical Support Notice as described in Section 401(b) of the Child Support Performance and Incentive Act of 1998 in the case of such child, and the Notice meets the criteria shown above for a qualified order, the Notice will be deemed to be a Qualified Medical Child Support Order in the case of such child.

FAMILY AND MEDICAL LEAVE ACT OF 1993

The Family and Medical Leave Act (FMLA) requires Employers who are subject to FMLA to allow their "eligible" Employees to take unpaid, job-protected leave. The Employer may also require or allow the Employee to substitute appropriate paid leave including, but not limited to, vacation and sick leave, if the Employee has earned or accrued it. The maximum leave required by FMLA is twelve (12) workweeks in any twelve (12) month period for certain family and medical reasons and a maximum combined total of twenty-six (26) workweeks during any twelve (12) month period for certain family and medical reasons and for a serious Injury or Illness of a member of the Armed Forces to allow the Employee, who is the spouse, son, daughter, parent, or next of kin to the member of the Armed Forces, to care for that member of the Armed Forces. In certain cases, this leave may be taken on an intermittent basis rather than all at once, or the Employee may work a part-time schedule.

DEFINITIONS

For these Family and Medical Leave Act of 1993 provisions only, the following definitions apply:

1. "Member of the Armed Forces" includes members of the National Guard or Reserves who are undergoing medical treatment, recuperation or therapy.

2. "Next of Kin" means the nearest blood relative to the service member.

3. "Parent" means Employee's biological parent or someone who has acted as Employee's parent in place of Employee's biological parent when Employee was a son or daughter.

4. "Serious health condition" means an Illness, Injury impairment, or physical or mental condition that involves:

   A. Inpatient care in a hospital, hospice, or residential medical facility; or

   B. Continuing treatment by a health care provider (a doctor of medicine or osteopathy who is authorized to practice medicine or surgery as appropriate, by the state in which the doctor practices or any other person determined by the Secretary of Labor to be capable of providing health care services).

5. "Serious Injury or Illness" means an Injury or Illness incurred in the line of duty that may render the member of the Armed Forces medically unfit to perform his or her military duties.

6. "Son or daughter" means Employee's biological child, adopted child, stepchild, legal foster child, a child placed in Employee's legal custody, or a child for which Employee is acting as the parent in place of the child's natural blood related parent. The child must be:

   A. Under the age of eighteen (18); or

   B. Over the age of eighteen (18), but incapable of self-care because of a mental or physical disability.

7. "Spouse" means a husband or wife as defined or recognized under state law for purposes of marriage in the state where the employee resides, including common law marriage and same-sex marriage.

EMPLOYERS SUBJECT TO FMLA

In general, FMLA applies to any employer engaged in interstate commerce or in any industry or activity affecting interstate commerce who employs 50 or more Employees for each working day during each of 20 or more calendar work weeks in the current or preceding Calendar Year. FMLA also applies to those persons described in Section 3(d) of the Fair Labor Standards Act, 29 U.S.C. 203(d). The FMLA applies to government entities, including branches of the United States government, state governments and political subdivisions thereof.

ELIGIBLE EMPLOYEES

Generally, an Employee is eligible for FMLA leave only if the Employee satisfies all of the following requirements as of the date on which any requested FMLA leave is to commence: (1) has been employed by the Employer for a total of at least twelve months (whether consecutive or not); (2) the Employee has worked (as defined under the Fair Labor Standards Act) at least 1,250 hours during the twelve-(12) month period immediately preceding the date the requested leave is to commence; (3) the Employee is employed in any state of the United States, the District of Columbia or any Territories or possession of the United States; and (4) at the time the leave is requested, the Employee is employed at a work site where 50 or more Employees are employed by the Employer within 75 surface miles of the work site.

REASONS FOR TAKING LEAVE

FMLA leave must be granted (1) to care for the Employee's newborn child; (2) to care for a child Placed For Adoption or foster care with the Employee; (3) to care for the Employee's spouse, son, daughter, or parent, who has a serious health condition; (4) because the Employee's own serious health condition prevents the Employee from performing his or her job; or (5) because of a qualifying exigency, as determined by the Secretary of Labor, arising out of the fact that a spouse, son, daughter or parent of the Employee is on active duty or has been called to active duty in the Armed Forces in support of a contingency operation (e.g., a war or national emergency declared by the President or Congress).

ADVANCE NOTICE AND MEDICAL CERTIFICATION

Ordinarily, an Employee must provide thirty (30) days advance notice when the requested leave is "foreseeable." If the leave is not foreseeable, the Employee must notify the Employer as soon as is practicable, generally within one to two working days. An employer may require medical certification to substantiate a request for leave requested due to a serious health condition. If the leave is due to the Employee's serious health condition, the Employer may require second or third opinions, at the Employer's expense, and a certification of fitness to return to work prior to allowing the Employee to return to work.

PROTECTION OF JOB BENEFITS

For the duration of FMLA leave, the Employer must maintain the Employee's health coverage under any "group health plan" on the same conditions as coverage would have been provided if the Employee had been in Active Service during FMLA leave period. Taking FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave, unless the loss would have occurred even if the Employee had been in Active Service.

UNLAWFUL ACTS BY EMPLOYERS

Employers cannot interfere with, restrain or deny the exercise of any right provided under the FMLA or to manipulate circumstances to avoid responsibilities under the FMLA. Employers may not discharge, or discriminate against any person who opposes any practice made unlawful by the FMLA or who may be involved in a proceeding under or relating to the FMLA.

ENFORCEMENT

The U.S. Department of Labor is authorized to investigate and resolve complaints of FMLA violations. An eligible Employee may also bring a civil action against an employer for FMLA violations. The FMLA does not supersede any federal or state law prohibiting discrimination, and does not supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights. For additional information, contact the nearest office of Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Participant's employment terminates; or

2. On the last day of the month in which the Participant ceases to be eligible for coverage; or

3. The date the Participant fails to make any required contribution for coverage; or

4. The date the Plan is terminated; or

5. The date the County terminates the Participant's coverage; or

6. The date the Participant dies; or

7. The date the Participant enters the armed forces of any country as a full-time member, if active duty is to exceed thirty-one (31) days; or

8. On the last day of the month in which the Plan receives the Plan’s Health Coverage Waiver Form for the Participant; or

9. For a Seasonal Employee, Paid Intern or variable hour Employee on the last day of the Coverage Period, unless at the expiration of the Coverage Period, the Participant is otherwise eligible as the result of a subsequent Measurement Period or as a result of being reclassified as a full-time Employee.

A Participant whose Active Service ceases because of Illness or Injury or as a result of any other approved leave of absence may remain covered as an Employee in Active Service for a period of twelve (12) weeks, or such other length of time that is consistent with and stated in the County's current Employee Personnel Policy Manual or pursuant to the Family and Medical Leave Act. Coverage under this provision will be subject to all the provisions of FMLA if the leave is classified as FMLA leave.

If a Participant's coverage is to be continued during disability, approved leave of absence or temporary layoff, the amount of his or her coverage will be the same as the Plan benefits in force for an active Employee, subject to the Plan’s right to amend coverage and benefits.

RETIREE TERMINATION

Coverage for a Retiree and eligible Dependents may continue until the earliest of the following dates:

1. The date the Retiree fails to make any required contribution for coverage; or

2. The date the Plan is terminated; or

3. The date the County terminates the Retiree's coverage; or

4. The date the Retiree dies; or

5. The date the Retiree enters the armed forces of any country as a full-time member, if active duty is to exceed thirty-one (31) days.

If a Retiree becomes deceased or terminates coverage under this Plan once the Retiree is eligible for Medicare, the spouse and eligible Dependent children who are covered at the time of the Retiree's death or termination of coverage may remain covered under the Plan until the earlier of the following:

1. The date the spouse becomes eligible for Medicare or eligible for any other individual or group health insurance or coverage; or

2. The date the Dependent child ceases to be eligible under this Plan or becomes eligible for any other individual or group health insurance or coverage.

DEPENDENT TERMINATION

Each Covered Person, whether Participant or Dependent, is responsible for notifying the Plan Administrator, within sixty (60) days after loss of Dependent status due to death, divorce, legal separation or ceasing to be an eligible Dependent child. Failure to provide this notice may result in loss of eligibility for COBRA Continuation Coverage After Termination.

Coverage for a Dependent will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month in which the Dependent ceases to be an eligible Dependent as defined by the Plan; or

2. On the last day of the month in which the Participant's coverage terminates under the Plan; or

3. On the last day of the month in which the Participant ceases to be eligible for Dependent Coverage; or

4. The date the Participant fails to make any required contribution for Dependent Coverage; or

5. The date the Plan is terminated; or

6. The date the County terminates the Dependent's coverage; or

7. On the last day of the month in which the Participant dies; or

8. On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the Dependent whose coverage is to be terminated.

REINSTATEMENT OF COVERAGE

An Employee whose coverage terminates by reason of termination of employment or reduction in hours and who again becomes eligible for coverage under the Plan within a thirteen (13) week period immediately following the date of such termination of employment or reduction in hours will become eligible for reinstatement of coverage on the date of renewed eligibility. Coverage will be reinstated for the Employee and eligible Dependents on the date of renewed eligibility, if covered on the date of termination, provided that application for such coverage is made on the Plan's enrollment platform within thirty (30) days after the date of renewed eligibility. Reinstatement of Coverage is subject to the following:

1. Credit will be given for prior amounts applied toward the Deductible and Out-of-Pocket Maximum for the same Benefit Period during which renewed eligibility occurs.

2. All prior accumulations toward annual or lifetime benefit maximums will apply.

If renewed eligibility occurs under any circumstances other than as stated in this subsection, enrollment for coverage for the Employee and his/her Dependents will be treated as if initially hired for purposes of eligibility and coverage under this Plan.

The Reinstatement of Coverage provision is not applicable to a variable hour Employee except for any period of time that the variable hour Employee is actually enrolled and covered during the Coverage Period.

VOLUNTARY SEPARATION INCENTIVE PROGRAM

Medical coverage provided by the County will be extended for those Employees eligible for the Voluntary Separation Incentive Program (VSIP). The Voluntary Separation Incentive Program (VSIP) will be extended to any regular full-time Employee who meets the eligibility criteria set forth by the action of the Board of County Commissioners. Under this Plan, if an eligible Employee chooses to take part in the program, the County will continue to pay the full premium costs for that Employee's medical benefits for a period of three (3) years, or will provide a financial incentive in lieu of benefits if the Employee so chooses.

1. Eligible Employees may elect to continue coverage at their current participation level (single or family).

2. Employees will not pay any premiums - the County will pay the premium costs for up to three (3) years.

3. Eligible Employees may select a blended option of medical and dental coverage, together with a partial cash payment.

Eligible Employees will have a period of sixty (60) days to enroll. The Plan enrollment period begins and ends as determined by the Employer. Employees who meet the Florida Retirement System (FRS) eligibility criteria outlined above between the dates specified by the Employer may also participate in this program. To participate, those who fall into this category will be required to enroll during the sixty (60) day window, but would not be considered to be enrolled into the Plan until the date they become eligible under Florida Retirement System (FRS) guidelines. Employees have a period of seven (7) calendar days during which time to change or revoke their participation. After that time period, their election is considered final.

RESCISSION OF COVERAGE

Coverage for an Employee and/or Dependent may be rescinded if the Plan Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation of a material fact in order to obtain coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

CONTINUATION COVERAGE AFTER TERMINATION

Under the Public Health Service Act, as amended, Employees and their enrolled Dependents may have the right to continue coverage beyond the time coverage would ordinarily have ended. The law applies to employers who normally employ twenty (20) or more employees.

The Plan Administrator is Collier County Government; 3311 East Tamiami Trail, Building D, Naples, FL 34112; (239) 252-8461. COBRA Continuation Coverage for the Plan is administered by Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, (406) 721-2222; facsimile (406) 523-3131; email COBRAinquire@askallegiance.com.

COBRA Continuation Coverage is available to any Qualified Beneficiary whose coverage would otherwise terminate due to any Qualifying Event. COBRA Continuation Coverage under this provision will begin on the first day following the date of the Qualifying Event.

1. Qualifying Events for Participants, for purposes of this section, are the following events, if such event results in a loss of coverage under this Plan:

   A. The termination (other than by reason of gross misconduct) of the Participant's employment.

   B. The reduction in hours of the Participant's employment.

2. Qualifying Events for covered Dependents, for purposes of this section are the following events, if such event results in a loss of coverage under this Plan:

   A. Death of the Participant or Retiree.

   B. Termination of the Participant's employment.

   C. Reduction in hours of the Participant's employment.

   D. The divorce or legal separation of the Participant or Retiree from his or her spouse.

   E. A covered Dependent child ceases to be a Dependent as defined by the Plan.

NOTIFICATION RESPONSIBILITIES

The Covered Person must notify the Employer of the following Qualifying Events within sixty (60) days after the date the event occurs. The Employer must notify the Plan Administrator of any of the following:

1. Death of the Participant or Retiree.

2. The divorce or legal separation of the Participant or Retiree from his or her spouse.

3. A covered Dependent child ceases to be a Dependent as defined by the Plan.

The Employer must notify the Plan Administrator of the following Qualifying Events within thirty (30) days after the date of the event occurs:

1. Termination (other than by reason of gross misconduct) of the Participant's employment.

2. Reduction in hours of the Participant's employment.

ELECTION OF COVERAGE

When the Plan Administrator is notified of a Qualifying Event, the Plan Administrator will notify the Qualified Beneficiary of the right to elect continuation of coverage. Notice of the right to COBRA Continuation Coverage will be sent by the Plan no later than fourteen (14) days after the Plan Administrator is notified of the Qualifying Event.

A Qualified Beneficiary has sixty (60) days from the date coverage would otherwise be lost or sixty (60) days from the date of notification from the Plan Administrator, whichever is later, to notify the Plan Administrator that he or she elects to continue coverage under the Plan. Failure to elect continuation within that period will cause coverage to end.

MONTHLY PREMIUM PAYMENTS

A Qualified Beneficiary is responsible for the full cost of continuation coverage. Monthly premium for continuation of coverage must be paid in advance to the Plan Administrator. The premium required under the provisions of COBRA is as follows:

1. For a Qualified Beneficiary: The premium is the same as applicable to any other similarly situated non-COBRA Participant plus an additional administrative expense of up to a maximum of two percent (2%).

2. Social Security Disability: For a Qualified Beneficiary continuing coverage beyond eighteen (18) months due to a documented finding of disability by the Social Security Administration within 60 days after becoming covered under COBRA, the premium may be up to a maximum of 150% of the premium applicable to any other similarly situated non-COBRA Participant.

3. For a Qualified Beneficiary with a qualifying Social Security Disability who experiences a second Qualifying Event:

    A. If another Qualifying Event occurs during the initial eighteen (18) months of COBRA coverage, such as a death, divorce or legal separation, the monthly fee for qualified disabled person may be up to a maximum of one hundred and two percent (102%) of the applicable premium.

    B. If the second Qualifying Event occurs during the nineteenth (19^{th}) through the twenty-ninth (29^{th}) month (the Disability Extension Period), the premium for a Qualified Beneficiary may be up to a maximum of one hundred fifty percent (150%) of the applicable premium.

Payment of claims while covered under this COBRA Continuation Coverage Provision will be contingent upon the receipt by the Employer of the applicable monthly premium for such coverage. The monthly premium for continuation coverage under this provision is due the first of the month for each month of coverage. A grace period of thirty (30) days from the first of the month will be allowed for payment. Payment will be made in a manner prescribed by the Employer.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If the Qualified Beneficiary who is covered under the Plan is determined by the Social Security Administration to be disabled at any time before the qualifying event or within sixty (60) days after the qualifying event, and the Plan Administrator is notified in a timely fashion, the Qualified Beneficiary covered under the Plan can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The Plan Administrator must be provided with a copy of the Social Security Administration's disability determination letter within sixty (60) days after the date of the determination and before the end of the original 18-month period of COBRA Continuation Coverage. This notice should be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806; facsimile (406) 523-3131; email COBRAinquire@askallegiance.com.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If another qualifying event occurs while receiving COBRA Continuation Coverage, the spouse and Dependent children of the Employee can get additional months of COBRA Continuation Coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and Dependent children if the former Employee dies or becomes divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child. **In all of these cases, the Plan Administrator must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806; facsimile (406) 523-3131; email COBRAinquire@askallegiance.com. Failure to provide notice within the time required will result in loss of eligibility for COBRA Continuation Coverage.**

MEDICARE ENROLLMENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

The Dependents of a former Employee are eligible to elect COBRA Continuation Coverage if they lose coverage as a result of the former Employee's enrollment in Part A , Part B or Part D of Medicare, whichever occurs earlier.

When the former Employee enrolls in Medicare before the Qualifying Event of termination, or reduction in hours, of employment occurs, the maximum period for COBRA Continuation Coverage for the spouse and Dependent children ends on the later of:

1. Eighteen (18) months after the Qualifying Event of termination of employment or reduction in hours of employment; or

2. Thirty-six (36) months after the former Employee's enrollment in Medicare.

When the former Employee enrolls in Medicare after the Qualifying Event of termination, or reduction in hours, of employment, the maximum period for COBRA Continuation Coverage for the spouse and Dependent children ends eighteen (18) months after the Qualifying Event, unless a second Qualifying Event, as described above occurs within that eighteen (18) month period.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA Continuation Coverage and any coverage under the Plan that has been elected with respect to any Qualified Beneficiary will cease on the earliest of the following:

1. On the date the Qualified Beneficiary becomes covered under another group health plan or health insurance.

2. On the date, after the date of election for COBRA Continuation Coverage, that the Qualified Beneficiary becomes enrolled in Medicare (either Part A, Part B or Part D).

3. On the first date that timely payment of any premium required under the Plan with respect to COBRA Continuation Coverage for a Qualified Beneficiary is not made to the Plan Administrator.

4. On the date the Employer ceases to provide any group health plan coverage to any Employee.

5. On the date of receipt of written notice that the Qualified Beneficiary wishes to terminate COBRA Continuation Coverage.

6. On the date that the maximum coverage period for COBRA Continuation Coverage ends, as follows:

    A. Eighteen (18) months for a former Employee who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment;

B. Eighteen (18) months for a Dependent who is a Qualified Beneficiary unless a second Qualifying Event occurs within that eighteen month period entitling that Dependent to an additional eighteen (18) months;

C. For the Dependent who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment of the former Employee if that former Employee enrolled in Medicare before termination, or reduction in hours, of employment, the later of eighteen (18) months from the Qualifying Event, or thirty-six (36) months following the date of enrollment in Medicare.

D. On the first day of the month beginning thirty (30) days after a Qualified Beneficiary is determined to be no longer disabled by the Social Security Administration if the Qualified Beneficiary was found to be disabled on or within the first sixty (60) days of the date of the Qualifying Event and has received at least eighteen (18) months of COBRA Continuation Coverage. COBRA Continuation Coverage will also terminate on such date for all Dependents who are Qualified Beneficiaries as a result of the Qualifying Event unless that Dependent is entitled to a longer period of COBRA Continuation Coverage without regard to disability.

E. Twenty-nine (29) months for any Qualified Beneficiary if a Disability Extension Period of COBRA Continuation Coverage has been granted for such Qualified Beneficiary.

F. Thirty-six (36) months for all other Qualified Beneficiaries.

7. On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Participant.

OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for Employees and their enrolled Dependents through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA Continuation Coverage. For more information visit www.HealthCare.gov.

In general for a person who is still employed, if enrollment in Medicare Part A or Part B is not made when first eligible, after the Medicare initial enrollment period, there is an 8-month special enrollment period to sign up for Medicare Part A or Part B, beginning on the earlier of:

1. The month after employment ends; or

2. The month after group health plan coverage based on current employment ends.

A Covered Person who elects COBRA Continuation Coverage instead of enrolling in Medicare may result in a significant surcharge by Medicare for late enrollment in Part B and there may be a gap in coverage if enrolling for Part B at a later time. If a Covered Person elects COBRA Continuation Coverage and later enrolls for Medicare Part A or Part B before the COBRA Continuation Coverage ends, the Plan may terminate COBRA Continuation Coverage for this individual. However, if Medicare Part A and Part B is effective on or before the date of the COBRA election, COBRA Continuation coverage may not be discontinued on account of Medicare entitlement, even if enrollment is made in the other part of Medicare after the date of the election of COBRA Continuation Coverage.

If enrolling in both COBRA Continuation Coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA Continuation Coverage will pay second (secondary payer). Certain plans may pay as if secondary to Medicare, even if not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

QUESTIONS

Any questions about COBRA Continuation Coverage should be directed to Allegiance COBRA Services, Inc. or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. For more information about the Marketplace visit www.HealthCare.gov.

INFORM THE PLAN OF ADDRESS CHANGES

In order to protect the Employee's family's rights, the Employee should keep the Plan Administrator informed of any changes in the addresses of family members. The Employee should also keep a copy, for his/her records, of any notices sent to the Plan Administrator.

COVERAGE FOR A MILITARY RESERVIST

To the extent required by the Uniform Services Employment and Reemployment Rights Act (USERRA), the following provisions will apply:

1. If a Participant is absent from employment with Employer by reason of service in the uniformed services, the Participant may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election will be the lesser of:

   A. The twenty-four (24) month period beginning on the date on which the Participant's absence begins; or

   B. The period beginning on the date on which the Participant's absence begins and ending on the day after the date on which the Participant fails to apply for or return to a position of employment, as required by USERRA.

2. A Participant who elects to continue Plan coverage under this Section may be required to pay not more than one hundred two percent (102%) of the full premium under the Plan (determined in the same manner as the applicable premium under Section 4980B(f)(4) of the Internal Revenue Code of 1986) associated with such coverage for the Employer's other Employees, except that in the case of a person who performs service in the uniformed services for less than thirty-one (31) days, such person may not be required to pay more than the regular Employee share, if any, for such coverage.

3. In the case of a Participant whose coverage under the Plan is terminated by reason of service in the uniformed services, an exclusion or Waiting Period may not be imposed in connection with the reinstatement of such coverage upon reemployment if an exclusion or Waiting Period would not have been imposed under the Plan had coverage of such person by the Plan not been terminated as a result of such service. This paragraph applies to the Employee who notifies the Employer of his or her intent to return to employment in a timely manner as defined by USERRA, and is reemployed and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of such Employee. **This provision will not apply to the coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been caused by or aggravated during, performance of service in the uniformed services.**

4. The requirements of this section shall not supersede any anti discrimination in coverage requirement promulgated by TRICARE or CHAMPVA related to eligibility for those coverages.

FRAUD AND ABUSE

THIS PLAN IS SUBJECT TO FEDERAL LAW WHICH PERMITS CRIMINAL PENALTIES FOR FRAUDULENT ACTS COMMITTED AGAINST THE PLAN. STATE LAW MAY ALSO APPLY.

Anyone who knowingly defrauds or tries to defraud the Plan, or obtains Plan funds through false statements or fraudulent schemes, may be subject to criminal prosecution and penalties. The following may be considered fraudulent:

1. Falsifying eligibility criteria for a Dependent;

2. Falsifying or withholding medical history or information required to calculate benefits;

3. Falsifying or altering documents to get coverage or benefits;

4. Permitting a person not otherwise eligible for coverage to use a Plan ID card to get Plan benefits; or

5. Submitting a fraudulent claim or making untruthful statements to the Plan to get reimbursement from the Plan for services that may or may not have been provided to a Covered Person.

The Plan Administrator, in its sole discretion, may take additional action against the Participant or Covered Person including, but not limited to, terminating the Participant or Covered Person's coverage under the Plan.

MISSTATEMENT OF AGE

If the Covered Person's age was misstated on an enrollment platform or claim, the Covered Person's eligibility or amount of benefits, or both, will be adjusted to reflect the Covered Person's true age. If the Covered Person was not eligible for coverage under the Plan or for the amount of benefits received, the Plan has a right to recover any benefits paid by the Plan. A misstatement of age will not continue coverage that was otherwise properly terminated or terminate coverage that is otherwise validly in force.

MISREPRESENTATION OF ELIGIBILITY

If a Participant misrepresents a Dependent's marital status, age, student status, Dependent child relationship or other eligibility criteria to get coverage for that Dependent, when he or she would not otherwise be eligible, coverage for that Dependent will terminate as though never effective.

MISUSE OF IDENTIFICATION CARD

If a Covered Person permits any person who is not otherwise eligible as a Covered Person to use an ID card, the Plan Sponsor may, at the Plan Sponsor's sole discretion, terminate the Covered Person's coverage.

REIMBURSEMENT TO PLAN

Payment of benefits by the Plan for any person who was not otherwise eligible for coverage under this Plan but for whom benefits were paid based upon fraud as defined in this section must be reimbursed to the Plan by the Participant. Failure to reimburse the Plan upon request may result in an interruption or a loss of benefits by the Participant and Dependents.

RESCISSION OF COVERAGE

Coverage for an Employee and/or Dependent may be rescinded if the Plan Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation of a material fact in order to obtain coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

RECOVERY/REIMBURSEMENT/SUBROGATION

By enrollment in this Plan, Covered Persons agree to the provisions of this section as a condition precedent to receiving benefits under this Plan. Failure of a Covered Person to comply with the requirements of this section may result in the Plan pending the payment of benefits.

RIGHT TO RECOVER BENEFITS PAID IN ERROR

If the Plan makes a payment in error to or on behalf of a Covered Person or an assignee of a Covered Person to which that Covered Person is not entitled, or if the Plan pays a claim that is not covered, the Plan has the right to recover the payment from the person paid or anyone else who benefitted from the payment. The Plan can deduct the amount paid from the Covered Person's future benefits, or from the benefits for any covered Family member even if the erroneous payment was not made on that Family member's behalf.

Payment of benefits by the Plan for any person who was not otherwise eligible for coverage under this Plan, but for whom benefits were paid based upon inaccurate or false information, or information omitted by the Participant must be reimbursed to the Plan by the Participant. The Participant's failure to reimburse the Plan after demand is made, may result in an interruption in or loss of benefits to the Participant and Dependents, and could be reported to the appropriate governmental authorities for investigation of criminal fraud.

The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine.

The provisions of this section apply to any Physician or Licensed Health Care Provider who receives an assignment of benefits or payment of benefits under this Plan. If a Physician or Licensed Health Care Provider fails to refund a payment of benefits, the Plan may refuse to recognize future assignments of benefits to that provider.

REIMBURSEMENT

The Plan's right to Reimbursement is separate from and in addition to the Plan's right of Subrogation. If the Plan pays benefits for medical expenses on a Covered Person's behalf, and another party was responsible or liable for payment of those medical expenses, the Plan has a right to be reimbursed by the Covered Person for the amounts the Plan paid.

Accordingly, if a Covered Person, or anyone on his or her behalf, settles, is reimbursed or recovers money from any person, corporation, entity, liability coverage, no-fault coverage, uninsured coverage, underinsured coverage, or other insurance policies or funds for any accident, Injury, condition or Illness for which benefits were provided by the Plan, the Covered Person agrees to hold the money received in trust for the benefit of the Plan. The Covered Person agrees to reimburse the Plan, in first priority, from any money recovered from a liable third party, for the amount of all money paid by the Plan to the Covered Person or on his or her behalf or that will be paid as a result of said accident, Injury, condition or Illness. Reimbursement to the Plan will be paid first, in its entirety, even if the Covered Person is not paid for all of his or her claim for damages and regardless of whether the settlement, judgment or payment he or she receives is for or specifically designates the recovery, or a portion thereof, as including health care, medical, disability or other expenses or damages.

SUBROGATION

The Plan's right to Subrogation is separate from and in addition to the Plan's right to Reimbursement. Subrogation is the right of the Plan to exercise the Covered Person's rights and remedies in order to recover from any third party who is liable to the Covered Person for a loss or benefits paid by the Plan. The Plan may proceed through litigation or settlement in the name of the Covered Person, with or without his or her consent, to recover benefits paid under the Plan.

The Covered Person agrees to subrogate to the Plan any and all claims, causes of action or rights that he or she has or that may arise against any entity who has or may have caused, contributed to or aggravated the accident, Injury, condition or Illness for which the Plan has paid benefits, and to subrogate any claims, causes of action or rights the Covered Person may have against any other coverage including, but not limited to, liability coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, or other insurance policies, coverage or funds.

In the event that a Covered Person decides not to pursue a claim against any third party or insurer, the Covered Person will notify the Plan, and specifically authorize the Plan, in its sole discretion, to sue for, compromise or settle any such claims in the Covered Person's name, to cooperate fully with the Plan in the prosecution of the claims, and to execute any and all documents necessary to pursue those claims.

The Following Paragraphs Apply to Both Reimbursement and Subrogation:

1. Under the terms of this Plan, the Plan Supervisor is not required to pay any claim where there is evidence of liability of a third party unless the Covered Person signs the Plan's Third-Party Reimbursement Agreement and follows the requirements of this section. However, the Plan, in its discretion, may instruct the Plan Supervisor not to withhold payment of benefits while the liability of a party other than the Covered Person is being legally determined. If a repayment agreement is requested to be signed, the Plan's right of recovery through Reimbursement and/or Subrogation remains in effect regardless of whether the repayment agreement is actually signed.

2. If the Plan makes a payment which the Covered Person, or any other party on the Covered Person's behalf, is or may be entitled to recover against any liable third party, this Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment.

3. The Covered Person will cooperate fully with the Plan Administrator, its agents, attorneys and assigns, regarding the recovery of any benefits paid by the Plan from any liable third party. This cooperation includes, but is not limited to, make full and complete disclosure in a timely manner of all material facts regarding the accident, Injury, condition or Illness to the Plan Administrator; report all efforts by any person to recover any such monies; provide the Plan Administrator with any and all requested documents, reports and other information in a timely manner, regarding any demand, litigation or settlement involving the recovery of benefits paid by the Plan; and notify the Plan Administrator of the amount and source of funds received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.

4. Covered Persons will respond within ten (10) days to all inquiries of the Plan regarding the status of any claim they may have against any third parties or insurers including, but not limited to, liability, no-fault, uninsured and underinsured insurance coverage. The Covered Person will notify the Plan immediately of the name and address of any attorney whom the Covered Person engages to pursue any personal Injury claim on his or her behalf.

5. The Covered Person will not act, fail to act, or engage in any conduct directly, indirectly, personally or through third parties, either before or after payment by the Plan, the result of which may prejudice or interfere with the Plan's rights to recovery hereunder. The Covered Person will not conceal or attempt to conceal the fact that recovery has occurred or will occur.

6. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any third party or coverage including, but not limited to, attorney fees or costs of litigation. Monies paid by the Plan will be repaid in full, in first priority, notwithstanding any anti-subrogation, "made whole," "common fund" or similar statute, regulation, prior court decision or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order or as limited by Florida state law.

RIGHT OF OFF-SET

The Plan has a right of off-set to satisfy reimbursement claims against Covered Persons for money received by the Covered Person from a third party, including any insurer. If the Covered Person fails or refuses to reimburse the Plan for funds paid for claims, the Plan may deny payment of future claims of the Covered Person, up to the full amount paid by the Plan and subject to reimbursement for such claims. This right of off-set applies to all reimbursement claims owing to the Plan whether or not formal demand is made by the Plan, and notwithstanding any anti-subrogation, "common fund," "made whole" or similar statutes, regulations, prior court decisions or common law theories.

PLAN ADMINISTRATION

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of the claim. The terms of this Plan are legally enforceable and the Plan is maintained for the exclusive benefit of eligible Employees and their covered Dependents.

EFFECTIVE DATE

The effective date of the Plan is January 1, 2000, restated January 1, 2025.

PLAN YEAR

The Plan Year will commence January 1 and end on December 31 of each year.

PLAN SPONSOR

The Plan Sponsor is Collier County Government.

PLAN SUPERVISOR

The Supervisor of the Plan is Allegiance Benefit Plan Management, Inc.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary is Collier County Government, a political subdivision of the State of Florida, who has the authority to control and manage the operation and administration of the Plan. The Plan Administrator will have the authority to amend the Plan, to determine its policies, to appoint and remove other service providers of the Plan, to fix their compensation (if any), and exercise general administrative authority over them and the Plan. The Plan Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The authority to perform the day to day Plan Administration duties as described in this paragraph is delegated to the Director, Risk Management (the designee), or his or her equivalent, whichever is applicable, of the County. The Director, Risk Management may temporarily delegate these responsibilities, as needed. This delegation shall not include the final selection of a Plan Supervisor, Actuarial firm, Benefits Consulting firm, or Reinsurance Stop Loss Carrier. This delegation shall include the review and approval of weekly claims disbursements reports and check registers presented to the Plan Administrator by the Plan Supervisor.

PLAN INTERPRETATION

The Named Fiduciary and the Plan Administrator have full discretionary authority to interpret and apply all Plan Provisions including, but not limited to, resolving all issues concerning eligibility and determination of benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Plan data, and perform other Plan-connected services. Final authority to interpret and apply the provisions of the Plan rests exclusively with the Plan Administrator. Decisions of the Plan Administrator made in good faith will be final and binding.

CONTRIBUTIONS TO THE PLAN

The amount of contributions to the Plan are to be made on the following basis:

The County will from time to time evaluate the costs of the Plan and determine the amount to be contributed by the County, if any, and the amount to be contributed, if any, by each Participant.

If the County terminates the Plan, the County and Participants will have no obligation to contribute to the Plan after the date of termination.

PLAN AMENDMENTS/MODIFICATION/TERMINATION

The Plan Document contains all the terms of the Plan and may be amended at any time by the County Manager or Plan Administrator. Any changes will be binding on each Participant and any other Covered Persons referred to in this Plan Document. The County Manager can delegate the authority to amend the Plan to either the Manager - Risk (Group Insurance)or the Director of Risk Management of the County. Any such amendment, modification, revocation or termination of the Plan will be authorized and signed by the following; County Manager, Manager - Risk (Group Insurance) or Director of Risk Management of the County; pursuant to a resolution, granting that individual the authority to amend, modify, revoke or terminate this Plan. A copy of the executed policy will be supplied to the Plan Supervisor. Written notification of any amendments, modifications, revocations or terminations will be given to Participants at least sixty (60) days prior to the effective date, except for amendments effective on the first day of a new Plan Year, for which thirty (30) days advance notice is required.

TERMINATION OF PLAN

The County reserves the right at any time to terminate the Plan by a written notice. All previous contributions by the County will continue to be issued for the purpose of paying benefits and fixed costs under provisions of this Plan with respect to claims arising before such termination, or will be used for the purpose of providing similar health benefits to Participants, until all contributions are exhausted.

PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

Each Participant covered under this Plan will be issued a Plan Document/Summary Plan Description (SPD) describing the benefits to which the Covered Persons are entitled, the required Plan procedures for eligibility and claiming benefits and the limitations and exclusions of the Plan.

GENERAL PROVISIONS

EXAMINATION

The Plan will have the right and opportunity to have the Covered Person examined whenever Injury or Illness is the basis of a claim when and so often as it may reasonably require to adjudicate the claim. The Plan will also have the right to have an autopsy performed in case of death to the extent permitted by law.

PAYMENT OF CLAIMS

All Plan benefits are payable to a Participant, Qualified Beneficiary or Alternate Recipient, whichever is applicable. All or a portion of any benefits payable by the Plan may, at the Covered Person's option and unless the Covered Person requests otherwise in writing not later than the time of filing the claim, be paid directly to the health care provider rendering the service, if proper written assignment is provided to the Plan. No payments will be made to any provider of services unless the Covered Person is liable for such expenses.

If any benefits remain unpaid at the time of the Covered Person's death or if the Covered Person is a minor or is, in the opinion of the Plan, legally incapable of giving a valid receipt and discharge for any payment, the Plan may, at its option, pay such benefits to the Covered Person's legal representative or estate. The Plan, in its sole option, may require that an estate, guardianship or conservatorship be established by a court of competent jurisdiction prior to the payment of any benefit. Any payment made under this subsection will constitute a complete discharge of the Plan's obligation to the extent of such payment and the Plan will not be required to oversee the application of the money so paid.

LEGAL PROCEEDINGS

No action at law or equity will be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor will such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan will be waived, and there will be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver will be deemed a continuing waiver unless specifically stated therein, and each such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

VERBAL STATEMENTS

Verbal statements or representations of the Plan Administrator, its agents and Employees, or Covered Persons will not create any right by contract, estoppel, unjust enrichment, waiver or other legal theory regarding any matter related to the Plan, or its administration, except as specifically stated in this subsection. No statement or representation of the Plan Administrator, its agents and Employees, or Covered Persons will be binding upon the Plan or a Covered Person unless made in writing by a person with authority to issue such a statement. This subsection will not be construed in any manner to waive any claim, right or defense of the Plan or a Covered Person based upon fraud or intentional material misrepresentation of fact or law.

FREE CHOICE OF PHYSICIAN

The Covered Person will have free choice of any licensed Physician, Licensed Health Care Provider or surgeon and the patient-provider relationship will be maintained.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, supplemental to Workers' Compensation and does not affect any requirement for coverage by Workers' Compensation Insurance.

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 the minimum requirements of the applicable law. Only that provision which is contrary to applicable law will be amended to conform; all other parts of the Plan will remain in full force and effect.

MISCELLANEOUS

Section titles are for convenience of reference only, and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect its right to enforce any other provision of the Plan.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Plan will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it determines in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the Plan will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same will be void, except an assignment of payment to a provider of Covered Services. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or which will become due to any Participant, the Plan Administrator, in its sole discretion, may terminate the interest of such Participant or former Participant in such payment. In such case, the Plan Administrator will apply the amount of such payment to or for the benefit of such Participant or covered Dependents or former Participant, as the Plan Administrator may determine. Any such application will be a complete discharge of all liability of the Plan with respect to such benefit payment.

PLAN IS NOT A CONTRACT

The Plan Document constitutes the primary authority for Plan administration. The establishment, administration and maintenance of this Plan will not be deemed to constitute a contract of employment, give any Participant of the County the right to be retained in the service of the County, or to interfere with the right of the County to discharge or otherwise terminate the employment of any Participant.

GENERAL DEFINITIONS

Certain words and phrases in this Plan Document are defined below. If the defined term is not used in this document, the term does not apply to this Plan. The failure of a word or phrase to appear capitalized does not waive the special meaning given to that word or phrase, unless the context requires otherwise. If the defined term is not used in this document, the term does not apply to this Plan.

Masculine pronouns used in this Plan Document will include either the masculine or feminine gender unless the context indicates otherwise.

Any words used herein in the singular or plural will include the alternative as applicable.

ACCIDENTAL INJURY

"Accidental Injury" means an Injury sustained as a result of an external force or forces that is/are sudden, direct and unforeseen and is/are exact as to time and place. A hernia of any kind will only be considered as an Illness.

ACTIVE SERVICE

"Active Service" means that an Employee is in service with the County on a day which is one of the County's regularly scheduled work days and that the Employee is performing all of the regular duties of his/her employment with the County on a regular basis, either at one of the County's business establishments or at some location to which the County's business requires him/her to travel.

ADVERSE BENEFIT DETERMINATION

"Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in the Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate, or a rescission of coverage if the Plan Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation of a material fact in order to obtain coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

ALCOHOLISM

"Alcoholism" means a morbid state caused by excessive and compulsive consumption of alcohol that interferes with the patient's health, social or economic functioning.

ALCOHOLISM AND/OR CHEMICAL DEPENDENCY

"Alcoholism" or "Chemical Dependency" means the physiological and psychological addiction to a controlled drug or substance, or to alcohol. Dependence upon tobacco, nicotine, caffeine or eating disorders are not included in this definition.

ALCOHOLISM AND/OR CHEMICAL DEPENDENCY TREATMENT FACILITY

"Alcoholism and/or Chemical Dependency Treatment Facility" means a licensed institution which provides a program for diagnosis, evaluation, and effective treatment of Alcoholism and/or Chemical Dependency; provides detoxification services needed with its effective treatment program; provides infirmary-level medical services or arranges with a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (RN) or Licensed Vocational Nurse (LVN); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician; and meets licensing standards.

AMBULANCE SERVICE

"Ambulance Service" means an entity, its personnel and equipment including, but not limited to, automobiles, airplanes, boats or helicopters, which are licensed to provide Emergency medical and Ambulance services in the state in which the services are rendered.

AMBULATORY SURGICAL CENTER

"Ambulatory Surgical Center" (also called same-day surgery center or Outpatient surgery center) means a licensed establishment with an organized staff of Physicians and permanent facilities, either freestanding or as a part of a Hospital, equipped and operated primarily for the purpose of performing surgical procedures and which a patient is admitted to and discharged from within a twenty-four (24) hour period. Such facilities must provide continuous Physician and registered nursing services whenever a patient is in the facility. An Ambulatory Surgical Center must meet any requirements for certification or licensing for ambulatory surgery centers in the state in which the facility is located.

"Ambulatory Surgical Center" does not include an office or clinic maintained by a Dentist or Physician for the practice of dentistry or medicine, a Hospital emergency room or trauma center.

AUTISM SPECTRUM DISORDER

"Autism Spectrum Disorder" means the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association: 1) autistic disorder; 2) Asperger's Syndrome; and 3) pervasive developmental disorder not otherwise specified.

BENEFIT PERCENTAGE

"Benefit Percentage" means that portion of Eligible Expenses payable by the Plan, which is stated as a percentage in the Schedule of Benefits.

BENEFIT PERIOD

"Benefit Period" refers to a time period of one year, which is either a Calendar Year or other annual period, as shown in the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one year period so established; or

2. The day the Maximum Lifetime Benefit applicable to the Covered Person becomes paid; or

3. The date the Plan terminates.

BIRTHING CENTER

"Birthing Center" means a freestanding or hospital based facility which provides obstetrical delivery services under the supervision of a Physician, and through an arrangement or an agreement with a Hospital.

CALENDAR YEAR

“Calendar Year” means a period of time commencing on January 1 and ending on December 31 of the same year.

CLOSE RELATIVE

“Close Relative” means the spouse, parent, brother, sister, child, or in-laws of the Covered Person.

COBRA

“COBRA” means Sections 2201 through 2208 of the Public Health Service Act [42 U.S.C. § 300bb-1 through § 300bb-8], which contains provisions similar to Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA CONTINUATION COVERAGE

“COBRA Continuation Coverage” means continuation coverage provided under the provisions of the Public Health Service Act referenced herein under the definition of “COBRA”.

CONVALESCENT NURSING FACILITY

See “Skilled Nursing Facility”.

COSMETIC

“Cosmetic” means services or treatment ordered or performed solely to change a Covered Person's appearance rather than for the restoration of bodily function.

COUNTY

“County” means Collier County Government or any affiliated agencies or boards that have adopted this Plan for its Employees.

COVERED PERSON

“Covered Person” means any Participant or Dependent of a Participant meeting the eligibility requirements for coverage and properly enrolled for coverage as specified in the Plan.

CUSTODIAL CARE

“Custodial Care” means the type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

DEDUCTIBLE

“Deductible” means a specified dollar amount that must be incurred before the Plan will pay any amount for any benefit during each Benefit Period.

DENTIST

“Dentist” means a person holding one of the following degrees–Doctor of Dental Science, Doctor of Medical Dentistry, Master of Dental Surgery or Doctor of Medicine (oral surgeon) -- who is legally licensed as such to practice dentistry in the jurisdiction where services are rendered, and the services rendered are within the scope of his or her license.

A “Dentist” will not include the Covered Person or any Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

DEPENDENT

“Dependent” means a person who is eligible for coverage under the Dependent Eligibility subsection of this Plan.

DEPENDENT COVERAGE

“Dependent Coverage” means eligibility for coverage under the terms of the Plan for benefits payable as a consequence of Eligible Incurred Expenses for an Illness or Injury of a Dependent.

DURABLE MEDICAL EQUIPMENT

“Durable Medical Equipment” means equipment which is:

1. Able to withstand repeated use, i.e., could normally be rented, and used by successive patients; and

2. Primarily and customarily used to serve a medical purpose; and

3. Not generally useful to a person in the absence of Illness or Injury.

ELIGIBLE EXPENSES

“Eligible Expenses” means the maximum amount of any charge for a covered service, treatment or supply that may be considered for payment by the Plan, including any portion of that charge that may be applied to the Deductible or used to satisfy the Out-of-Pocket Maximum. Eligible Expenses are equal to the actual billed charge or UCR, whichever is less or a contracted or negotiated rate, if applicable.

EMERGENCY

“Emergency” means acute symptoms that a prudent layperson with average knowledge of health and medicine would expect that the absence of medical attention would place the individual’s health in serious jeopardy or seriously impair body functions, organs or parts.

EMPLOYEE

“Employee” means a person employed by the Employer on a continuing and regular basis who is a common-law Employee and who is on the Employer’s W-2 payroll.

Employee does not include any employee leased from another employer including, but not limited to, those individuals defined in Internal Revenue Code Section 414(n), or an individual classified by the Employer as a contract worker or independent contractor if such persons are not on the Employer’s W-2 payroll, or any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as “Kelly,” “Manpower,” etc.

EMPLOYER

“Employer” means Collier County Government or any affiliated agencies or boards that have adopted this Plan for its Employees.

ENROLLMENT DATE

“Enrollment Date” means the date a person becomes eligible for coverage under this Plan or the eligible person’s effective date of coverage under this Plan, whichever occurs first.

EXPERIMENTAL/INVESTIGATIONAL

"Experimental/Investigational" means:

1. Any drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. Any drug, device, medical treatment or procedure for which the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

3. That the drug, device or medical treatment or procedure is under study, prior to or in the absence of any clinical trial, to determine its maximum tolerated dose, its toxicity, or its safety; or

4. That based upon Reliable Evidence, the drug, device, medical treatment or procedure is the subject of an on-going Phase I or Phase II clinical trial. (A Phase III clinical trial recognized by the National Institute of Health is not considered Experimental or Investigational.) For chemotherapy regimens, a Phase II clinical trial is not considered Experimental or Investigational when both of these criteria are met:

    A. The regimen or protocol has been the subject of a completed and published Phase II clinical trial which demonstrates benefits equal to or greater than existing accepted treatment protocols, and

    B. The regimen or protocol listed by the National Comprehensive Cancer Network is supported by level of evidence Category 2B or higher; or

5. Based upon Reliable Evidence, any drug, device, medical treatment or procedure that the prevailing opinion among experts is that further studies or clinical trial are necessary to determine the maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally medically accepted means of treatment or diagnosis; or

6. Any drug, device, medical treatment or procedure used in a manner outside the scope of use for which it was approved by the FDA or other applicable regulatory authority (U.S. Department of Health, Centers for Medicare and Medicaid Services (CMS), American Dental Association, American Medical Association).

"Reliable Evidence" means only reports and articles published in authoritative medical and scientific literature; the written protocol or protocols used by a treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

FAMILY

"Family" means a Participant and his or her eligible Dependents as defined herein.

FMLA

"FMLA" means Family and Medical Leave Act.

GENDER IDENTITY DISORDER/ GENDER DYSPHORIA

DSM-V diagnosis in children:

1. A definite difference between experienced/expressed gender and the one assigned at birth of at least six (6) months duration. At least six (6) of the following must be present:

   A. Persistent and strong desire to be of the other sex or insistence that they belong to the other sex.

   B. In male children, a strong preference for cross-dressing and in female children, a strong preference for wearing typical masculine clothing and dislike or refusal to wear typical feminine clothing.

   C. Fantasizing about playing opposite gender roles in make-belief play or activities.

   D. Preference for toys, games or activities typical of the opposite sex.

   E. Rejection of toys, games and activities conforming to one's own sex. In male children, avoidance of rough-and-tumble play, and in female children, rejection of typically feminine toys, games and activities.

   F. Preference for playmates of the other sex.

   G. Dislike for sexual anatomy. Male children may hate their penis and testes, and female children may dislike urinating sitting.

   H. Desire to acquire the primary and/or secondary sex characteristics of the opposite sex.

2. The gender dysphoria leads to clinically significant distress and/or social, occupational and other functioning impairment. There may be an increased risk of suffering distress or disability.

The subtypes may be ones with or without defects or defects in sexual development.

DSM-V diagnosis in adolescents and adults:

1. A definite mismatch between the assigned gender and experienced/expressed gender for at least six (6) months duration as characterized by at least two (2) or more of the following features:

   A. Mismatch between experienced or expressed gender and gender manifested by primary and/or secondary sex characteristics at puberty.

   B. Persistent desire to rid oneself of the primary or secondary sexual characteristics of the biological sex at puberty.

   C. Strong desire to possess the primary and/or secondary sex characteristics of the other gender.

   D. Desire to belong to the other gender.

   E. Desire to be treated as the other gender.

   F. Strong feeling or conviction that he or she is reacting or feeling in accordance with the identified gender.

2. The gender dysphoria leads to clinically significant distress and/or social, occupational and other functioning impairment. There may be an increased risk of suffering distress or disability.

The subtypes may be ones with or without defects or defects in sexual development.

HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

HOME HEALTH CARE AGENCY

"Home Health Care Agency" means an organization that provides skilled nursing services and therapeutic services (home health aide services, physical therapy, occupational therapy, speech therapy, medical social services) on a visiting basis, in a place of residence used as the Covered Person's home. The organization must be Medicare certified and licensed within the state in which home health care services are provided.

HOME HEALTH CARE PLAN

"Home Health Care Plan" means a program for continued care and treatment administered by a Medicare certified and licensed Home Health Care Agency, for the Covered Person who may otherwise have been confined as an Inpatient in a Hospital or Skilled Nursing Facility or following termination of a Hospital confinement as an Inpatient and is the result of the same related condition for which the Covered Person was hospitalized and is approved in writing by the Covered Person's attending Physician.

HOSPICE

"Hospice" means a health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse (RN) or Licensed Vocational Nurse (LVN), and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPICE BENEFIT PERIOD

"Hospice Benefit Period" means a specified amount of time during which the Covered Person undergoes treatment by a Hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminal Illness, and the Covered Person is accepted into a Hospice program. The period will end the earliest of six months from this date or at the death of the Covered Person. A new Hospice Benefit Period may begin if the attending Physician certifies that the patient is still terminally ill; however, additional proof will be required by the Plan Administrator before a new Hospice Benefit Period can begin.

HOSPITAL

"Hospital" means an institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an emergent or Inpatient basis at the patient's expense; and

2. It is licensed as a hospital or a critical access hospital under the laws of the jurisdiction in which the facility is located; and

3. It maintains on its premises the facilities necessary to provide for the diagnosis and treatment of an Illness or an Injury or provides for the facilities through arrangement or agreement with another hospital; and

4. It provides treatment by or under the supervision of a Physician or osteopathic Physician with nursing services by registered nurses as required under the laws of the jurisdiction in which the facility is licensed; and

5. It is a provider of services under Medicare. This condition is waived for otherwise Eligible Incurred Expenses outside of the United States; and

6. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

HOSPITAL MISCELLANEOUS EXPENSES

"Hospital Miscellaneous Expenses" mean the actual charges made by a Hospital on its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services, regardless of whether the services are rendered under the direction of the Hospital or otherwise.

ILLNESS

"Illness" means a bodily disorder, Pregnancy, disease, physical sickness, Mental Illness , or functional nervous disorder of a Covered Person.

INCURRED EXPENSES OR EXPENSES INCURRED

"Incurred Expenses" or "Expenses Incurred" means those services and supplies rendered to a Covered Person. Such expenses will be considered to have occurred at the time or date the treatment, service or supply is actually provided.

INITIAL ENROLLMENT PERIOD

"Initial Enrollment Period" means the time allowed by this Plan for enrollment when a person first becomes eligible for coverage.

INJURY

"Injury" means physical damage to the Covered Person's body which is not caused by disease or bodily infirmity.

INPATIENT

"Inpatient" means the classification of a Covered Person when that person is admitted to a Hospital, Hospice, or Skilled Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such treatment.

INTENSIVE CARE UNIT

"Intensive Care Unit" means a section, ward, or wing within the Hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;

2. It has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and

3. It provides constant observation and treatment by Registered Nurses (RNs) or other highly-trained Hospital personnel.

LICENSED HEALTH CARE PROVIDER

"Licensed Health Care Provider" means any provider of health care services who is licensed or certified by any applicable governmental regulatory authority to the extent that services are within the scope of the license or certification and are not specifically excluded by this Plan.

LICENSED PRACTICAL NURSE

"Licensed Practical Nurse" (LPN) means an individual who has received specialized nursing training and practical nursing experience, and is licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LICENSED SOCIAL WORKER

"Licensed Social Worker" (LSW) means a person holding a Master's Degree (MSW) in social work and who is currently licensed as a social worker in the state in which services are rendered, and who provides counseling and treatment in a clinical setting for Mental Illnesses.

LICENSED VOCATIONAL NURSE

"Licensed Vocational Nurse" (LVN) means an individual who has received specialized nursing training and practical nursing experience, and is licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

MAINTENANCE THERAPY

"Maintenance Therapy" means medical and non-medical health-related services that do not seek to cure, or that which are provided during periods when the medical condition of the patient is not changing, or does not require continued administration by medical personnel.

MAXIMUM LIFETIME BENEFIT

"Maximum Lifetime Benefit" means the maximum benefit payable while a person is covered under this Plan. The Maximum Lifetime Benefit will not be construed as providing lifetime coverage, or benefits for a person's Illness or Injury after coverage terminates under this Plan.

MEDICAID

"Medicaid" means that program of medical care and coverage established and provided by Title XIX of the Social Security Act, as amended.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

"Medically Necessary" or "Medical Necessity" means treatment, tests, services or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under this Plan and which meet all of the following criteria:

1. Are to treat or diagnose an Illness or Injury; and

2. Are ordered by a Physician or Licensed Health Care Provider and are consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and

3. Are not primarily for the convenience of the Covered Person, Physician or other Licensed Health Care Provider; and

4. Are the standard or level of services most appropriate for good medical practice that can be safely provided to the Covered Person and are in accordance with the Plan's Medical Policy; and

5. Are not of an Experimental/Investigational or solely educational nature; and

6. Are not provided primarily for medical or other research; and

7. Do not involve excessive, unnecessary or repeated tests; and

8. Are commonly and customarily recognized by the medical profession as appropriate in the treatment or diagnosis of the diagnosed condition; and

9. Are approved procedures or meet required guidelines or protocols of the Food and Drug Administration (FDA) or Centers For Medicare/Medicaid Services (CMS), pursuant to that entity's program oversight authority based upon the medical treatment circumstances.

MEDICAL POLICY

"Medical Policy" means a policy adopted by the Plan which is created and updated by Physicians and other medical providers and is used to determine whether health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;

2. Scientific studies showing conclusive evidence of improved net health outcome; and

3. In accordance with any established standards of good medical practice.

MEDICARE

"Medicare" means the programs established under the "Health Insurance for the Aged Act," Public Law 89-97 under Title XVIII of the Federal Social Security Act, as amended, to pay for various medical expenses for qualified individuals, specifically those who are eligible for Medicare Part A , Part B or Part D as a result of age, those with end-stage renal disease, or with disabilities.

MENTAL ILLNESS

"Mental Illness" means a medically recognized psychological, physiological, nervous or behavioral condition, affecting the brain, which can be diagnosed and treated by medically recognized and accepted methods, **but will not include Alcoholism, Chemical Dependency or other addictive behavior**. Conditions recognized by the Diagnostic Statistical Manual (the most current edition) will be included in this definition.

MORBID OBESITY/CLINICALLY SEVERE OBESITY

"Morbid Obesity/Clinically Severe Obesity" means maintaining a Body Mass Index (BMI) of 40 or more for a period of at least 12 consecutive months, or a BMI of at least 35 for a period of at least 12 consecutive months, combined with at least one of the following conditions which must be documented by a Physician as life-threatening:

1. Severe sleep apnea;

2. Pickwickian syndrome;

3. Congestive heart failure;

4. Cardiomyopathy;

5. Insulin dependent or oral medication dependent diabetes;

6. Severe Musculoskeletal dysfunction;

7. Gastric Esophageal Reflux Disorder;

8. Pulmonary edema; or

9. Hypertension.

Body Mass Index (BMI) is calculated by dividing a person's weight (in kilograms) by his/her height squared (in meters).

NAMED FIDUCIARY

"Named Fiduciary" means the Plan Administrator which has the authority to control and manage the operation and administration of the Plan.

NEWBORN

"Newborn" refers to an infant from the date of his/her birth until the initial Hospital discharge or forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean section, whichever occurs first.

OCCUPATIONAL THERAPY

"Occupational Therapy" means a program of care ordered by a Physician which is for the purpose of improving the physical, cognitive and perceptual disabilities that influence the Covered Person's ability to perform functional tasks related to normal life functions or occupations, and which is for the purpose of assisting the Covered Person in performing such functional tasks without assistance.

ORTHOPEDIC APPLIANCE

"Orthopedic Appliance" means a rigid or semi-rigid support used to restrict or eliminate motion in a diseased, injured, weak or deformed body member.

OUT-OF-POCKET MAXIMUM

"Out-of-Pocket Maximum" means the maximum dollar amount, as stated in the Schedule of Medical Benefits or Pharmacy Benefit, that any Covered Person or Family will pay in any Benefit Period for covered services, treatments or supplies.

OUTPATIENT

"Outpatient" means a Covered Person who is receiving medical care, treatment, services or supplies at a clinic, a Physician's office, a Licensed Health Care Provider's office or at a Hospital if not a registered bed patient at that Hospital, Psychiatric Facility or Alcoholism and/or Chemical Dependency Treatment Facility.

PARTIAL HOSPITALIZATION

"Partial Hospitalization" means care in a day care or night care facility for a minimum of twenty (20) hours per week, during which therapeutic clinical treatment is provided.

PARTICIPANT

"Participant" means an Employee of the County who is eligible and enrolled for coverage under this Plan.

PHYSICAL THERAPY

"Physical Therapy" means a plan of care ordered by a Physician and provided by a licensed physical therapist, to return the Covered Person to the highest level of motor functioning possible.

PHYSICIAN

"Physician" means a person holding the degree of Doctor of Medicine, Dentistry or Osteopathy, or Optometry who is legally licensed as such.

"Physician" does not include the Covered Person or any Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

PLACEMENT OR PLACED FOR ADOPTION

"Placement" or "Placed for Adoption" means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

PLAN

"Plan" means the Collier County Government Employee Benefit Plan, the Plan Document and any other relevant documents pertinent to its operation and maintenance.

PLAN ADMINISTRATOR

"Plan Administrator" means the County and/or its designee which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. For the purposes of any applicable state legislation of a similar nature, the County will be deemed to be the Plan Administrator of the Plan unless the County designates an individual or committee to act as Plan Administrator of the Plan.

PLAN SUPERVISOR

"Plan Supervisor" means the person or firm employed by the Plan to provide consulting services to the Plan in connection with the operation of the Plan and any other functions, including the processing and payment of claims. The Plan Supervisor is Allegiance Benefit Plan Management, Inc. The Plan Supervisor provides ministerial duties only, exercises no discretion over Plan assets and will not be considered a fiduciary as defined by any other State or Federal law or regulation.

PREGNANCY

"Pregnancy" means a physical condition commencing with conception, and ending with miscarriage or birth.

PRIMARY CARE PHYSICIAN

"Primary Care Physician" (PCP) includes a general practitioner, family practitioner, Internist, OB/GYN (obstetrics/gynecology), Pediatrician, Psychiatrist, Licensed Nurse Practitioners, Licensed Vocational Nurse or Physician Assistants.

PREVENTIVE CARE

"Preventive Care" means routine treatment or examination provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, and which is not provided as a result of any Injury or Illness.

PROSTHETIC APPLIANCE

"Prosthetic Appliance" means a device or appliance that is designed to replace a natural body part lost or damaged due to Illness or Injury, the purpose of which is to restore full or partial bodily function or appearance, or in the case of Covered Dental Benefit, means any device which replaces all or part of a missing tooth or teeth.

PSYCHIATRIC CARE

"Psychiatric Care," also known as psychoanalytic care, means treatment for a Mental Illness or disorder, a functional nervous disorder, Alcoholism or drug addiction by a licensed psychiatrist, Psychologist, Licensed Social Worker or licensed professional counselor acting within the scope and limitations of his/her respective license, provided that such treatment is Medically Necessary as defined by the Plan, and within recognized and accepted professional psychiatric and psychological standards and practices.

PSYCHIATRIC FACILITY

"Psychiatric Facility" means a licensed institution that provides Mental Illness treatment and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

PSYCHOLOGIST

"Psychologist" means a person currently licensed in the state in which services are rendered as a Psychologist and acting within the scope of his/her license.

QMCSO

"QMCSO" means Qualified Medical Child Support Order as defined by Section 609(a) of ERISA, as amended.

QUALIFIED BENEFICIARY

"Qualified Beneficiary" means an Employee, former Employee or Dependent of an Employee or former Employee who is eligible to continue coverage under the Plan in accordance with applicable provisions of Title X of COBRA or Section 609(a) of ERISA in relation to QMCSO.

"Qualified Beneficiary" will also include a child born to, adopted by or Placed for Adoption with an Employee or former Employee at any time during COBRA Continuation Coverage.

REGISTERED NURSE

"Registered Nurse" (RN) means an individual who has received specialized nursing training and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

REHABILITATION FACILITY

"Rehabilitation Facility" means a facility that meets all of the following requirements:

1. Care must be for the treatment of acute Injury or Illness;
2. Is licensed as an acute rehabilitation facility;
3. The care is under the direct supervision of a Physician;
4. Services are Medically Necessary;
5. Services are specific to an active written treatment plan;
6. The patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care;
7. Twenty-four (24) hour nursing services are available; and
8. The confinement is not for Custodial or maintenance care.

RESIDENTIAL TREATMENT FACILITY

"Residential Treatment Facility" (RTF) means a facility for purposes of evaluation and treatment or evaluation and referral of any individual with Alcoholism/Chemical Dependency or Mental Illness. Treatment received in a Residential setting for Mental Illness or Alcoholism/Chemical Dependency treatment that is provided in a less restrictive manner than are Inpatient services, but in a more intensive manner than are Outpatient services.

RETIREE

"Retiree" means an Employee who retires under a retirement program authorized by law and eligible to continue coverage with the Employer pursuant to the terms of Florida statute 112.0801, as amended.

ROOM AND BOARD

"Room and Board" refers to all charges which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

SKILLED NURSING FACILITY

"Skilled Nursing Facility" means an institution, or distinct part thereof, which meets all of the following conditions:

1. It is currently licensed as a long-term care facility or skilled nursing facility in the state in which the facility is located;

2. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled persons, custodial or educational care, or care of mental disorders; and

3. It is certified by Medicare.

This term also applies to Incurred Expenses in an institution known as a Convalescent Nursing Facility, Extended Care Facility, Convalescent Nursing Home, or any such other similar nomenclature.

SPECIAL ENROLLMENT PERIOD

"Special Enrollment Period" means a period of time allowed under this Plan, other than the eligible person's Initial Enrollment Period or an Open Enrollment Period, during which an eligible person can request coverage under this Plan as a result of certain events that create special enrollment rights.

SPECIALTY CARE PHYSICIAN

"Specialty Care Physician" (SCP) includes any Physician practicing any branch of medicine or medical specialty who is not otherwise a Primary Care Physician.

SPEECH THERAPY

"Speech Therapy" means a course of treatment, ordered by a Physician, to treat speech deficiencies or impediments.

TELEMEDICINE

"Telemedicine" means the practice of medicine by electronic means, only for the purposes of diagnosis, providing medical advice and treatment to the Covered Person (patient), requiring direct contact between the Covered Person's Physician or other Licensed Health Care Providers or entities in a different location. The Covered Person's direct participation or physical presence is not a prerequisite for coverage if there is documentation that the consultation was conducted on behalf of the Covered Person for the purpose of diagnosing, providing medical advice or treatment to the Covered Person.

URGENT CARE FACILITY

"Urgent Care Facility" means a free-standing facility which is engaged primarily in diagnosing and treating Illness or Injury for unscheduled, ambulatory Covered Persons seeking immediate medical attention. A clinic or office located in or in conjunction with or in any way made a part of a Hospital will be excluded from the terms of this definition.

USERRA

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act, as amended.

USUAL, CUSTOMARY AND REASONABLE

"Usual, Customary and Reasonable" (UCR) means the maximum amount considered for payment by this Plan for any covered treatment, service, or supply, subject however, to all Plan annual and Maximum Lifetime Benefit limitations. The following will apply in the order below to determine the Usual, Customary and Reasonable amount:

1. A contracted amount as established by a preferred provider or other discounting contract; or

2. An amount established through a nationally recognized, published Usual, Customary and Reasonable (UCR) database utilized by the Plan Supervisor and adopted by the Plan Administrator using the 90th percentile of said database; or

3. The billed charge if less than 2 above.

For non-contracted providers for Emergency service, Air Ambulance and non-contracted providers providing services in a contracted facility, the UCR is equal to and used as the Qualified Payment Amount for No Surprise Billing Act purposes.

NOTICES

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

IDENTIFICATION OF FUNDING: Benefits under this Plan will be paid from Employee or Employer contributions up to the limits defined in the Plan Document/Summary Plan Description (SPD). Benefits in excess of the amount stated in the stop loss policy are reimbursable to the Employer by stop loss insurance, pursuant to the stop loss insurance contract or policy, subject, however, to the terms of this Plan and the stop loss insurance contract.

WOMEN'S HEALTH AND CANCER RIGHTS ACT: This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all states of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call the Plan Administrator for more information.

HIPAA PRIVACY AND SECURITY STANDARDS

These standards are intended to comply with all requirements of the Privacy and Security Rules of the Administrative Simplification Rules of HIPAA as stated in 45 CFR Parts 160, 162 and 164, as amended from time to time.

DEFINITIONS

"Protected Health Information" (PHI) means information, including demographic information, that identifies an individual and is created or received by a health care provider, health plan, employer, or health care clearinghouse, and relates to the physical or mental health of an individual, health care that individual has received, or the payment for health care provided to that individual. PHI does not include employment records held by the Plan Sponsor in its role as an Employer.

"Summary Health Information" means information summarizing claims history, expenses, or types of claims by individuals enrolled in a group health plan and has had the following identifiers removed: names; addresses, except for the first three digits of the ZIP Code; dates related to the individual (ex: birth date); phone numbers; email addresses and related identifiers; social security numbers; medical record numbers; account or Participant numbers; vehicle identifiers; and any photo or biometric identifier.

PRIVACY CERTIFICATION

The Plan Sponsor hereby certifies that the Plan Documents have been amended to comply with the privacy regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Documents or as required by law. Such uses or disclosures may be for the purposes of Plan administration including, but not limited to, the following:

    A. Operational activities such as quality assurance and utilization management, credentialing, and certification or licensing activities; underwriting, premium rating or other activities related to creating, renewing or replacing health benefit contracts (including reinsurance or stop loss); compliance programs; business planning; responding to appeals, external reviews, arranging for medical reviews and auditing, and customer service activities. Plan administration can include management of carve-out plans, such as dental or vision coverage.

    B. Payment activities such as determining eligibility or coverage, coordination of benefits, determination of cost-sharing amounts, adjudicating or subrogating claims, claims management and collection activities, obtaining payment under a contract for reinsurance or stop-loss coverage, and related data-processing activities; reviewing health care services for Medical Necessity, coverage or appropriateness of care, or justification of charges; or utilization review activities.

    C. For purposes of this certification, Plan administration does not include disclosing Summary Health Information to help the Plan Sponsor obtain premium bids; or to modify, amend or terminate group health plan coverage. Plan administration does not include disclosure of information to the Plan Sponsor as to whether the individual is a participant in; is an enrollee of or has disenrolled from the group health plan.

2. Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

5. Make available PHI as required to allow the Covered Person a right of access to his or her PHI as required and permitted by the regulations;

6. Make available PHI for amendment and incorporate any amendments into PHI as required and permitted by the regulations;

7. Make available the PHI required to provide an accounting of disclosures as required by the regulations;

8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to any applicable regulatory authority for purposes of determining the Plan's compliance with the law's requirements;

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

10. Ensure that the adequate separation required between the Plan and the Plan Sponsor is established. To fulfill this requirement, the Plan Sponsor will restrict access to nonpublic personal information to the Plan Administrator(s) designated in this Plan Document or Employees designated by the Plan Administrator(s) who need to know that information to perform Plan administration and healthcare operations functions or assist eligible persons enrolling and disenrolling from the Plan. The Plan Sponsor will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator(s) and any Employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies the Plan Sponsor establishes to secure such information.

When information is disclosed to entities that perform services or functions on the Plan's behalf, such entities are required to adhere to procedures and practices that maintain the confidentiality of the Covered Person's nonpublic personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable privacy laws.

SECURITY CERTIFICATION

The Plan Sponsor hereby certifies that its Plan Documents have been amended to comply with the security regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Implement and follow all administrative, physical, and technical safeguards of the HIPAA Security Rules, as required by 45 CFR §§164.308, 310 and 312.

2. Implement and install adequate electronic firewalls and other electronic and physical safeguards and security measures to ensure that electronic PHI is used and disclosed only as stated in the Privacy Certification section above.

3. Ensure that when any electronic PHI is disclosed to any entity that performs services or functions on the Plan's behalf, that any such entity shall be required to adhere to and follow all of the requirements for security of electronic PHI found in 45 CFR §§164.308, 310, 312, 314 and 316.

4. Report to the Plan Administrator or the Named Fiduciary of the Plan any attempted breach, or breach of security measures described in this certification, and any disclosure or attempted disclosure of electronic PHI of which the Plan Sponsor becomes aware.

PLAN SUMMARY

The following information, together with the information contained in this booklet, form the Plan Document/Summary Plan Description.

1. PLAN NAME

   The name of the Plan is the COLLIER COUNTY GOVERNMENT EMPLOYEE BENEFIT PLAN, which Plan describes the benefits, terms, limitations and provisions for payment of benefits to or on behalf of eligible Participants.

2. PLAN BENEFITS

   This Plan provides benefits for covered Expenses Incurred by eligible participants for:

   Hospital, Surgical, Medical, Maternity, Pharmacy other eligible medically related, necessary expenses.

3. PLAN EFFECTIVE DATE

   This Plan was established effective January 1, 2000, and restated January 1, 2025.

4. PLAN SPONSOR

   Name: Collier County Government
   Phone (239) 252-8461
   Address: 3311 East Tamiami Trail, Building D
   Naples, FL 34112

5. PLAN ADMINISTRATOR

   The Plan Administrator is the Plan Sponsor.

6. NAMED FIDUCIARY

   Name: Collier County Government
   Phone (239) 252-8461
   Address: 3311 East Tamiami Trail, Building D
   Naples, FL 34112

7. PLAN FISCAL YEAR

   The Plan fiscal year ends December 31.

8. PLAN YEAR

   The Plan Year will commence January 1 and end on December 31 of each year.

9. PLAN TERMINATION

   The right is reserved by the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

10. IDENTIFICATION NUMBER

Plan Number:	501
Group Number:	2003021
Employer Identification Number:	59-6000558

11. PLAN SUPERVISOR

Name:	Allegiance Benefit Plan Management, Inc.
Address:	P.O. Box 3018 Missoula, MT 59806

12. ELIGIBILITY

Employees and Dependents of Employees of the Plan Sponsor may participate in the Plan based upon the eligibility requirements set forth by the Plan.

13. PLAN FUNDING

The Plan is funded by contributions from the Employer and Employees.

14. AGENT FOR SERVICE OF LEGAL PROCESS

The Plan Administrator is the agent for service of legal process.

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