Summary Plan Description

Sarasota Memorial Health Care System

Health and Wellness Plan

Effective October 1, 2017
For Fiscal Year 2018

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INTRODUCTION

SMH Health Care, Inc. (SMHCS), the "Plan Sponsor", has retained the services of an independent Third Party Administrator, WEBTPA, experienced in claims processing to process medical claims.

Funding for the Plan is provided by the Plan Sponsor from the combination of your contributions and funding provided by SMHCS. The Plan Sponsor has purchased excess risk insurance coverage which is intended to reimburse the Plan Sponsor for certain losses incurred and paid under the Plan by the Plan Sponsor. The excess risk insurance coverage is not a part of the Plan.

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

The Employer intends to maintain this Plan indefinitely. However, the Employer has the right to modify or terminate this Plan at any time, and for any reason, as to any part or in its entirety, without advance notice. If the Plan is amended or terminated, you may not receive benefits described in this Summary Plan Description. If the Plan is amended, you may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage would end. This may happen at any time, and in no event will you become entitled to any vested rights under this Plan that would prevent the Plan from either being amended or terminated.

You are entitled to the coverage provided by the Plan if the eligibility provisions of the Plan have been satisfied. This booklet is void if you have ceased to be entitled to coverage. No clerical error will invalidate your coverage if otherwise validly in force.

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

SMHCS provides a flexible benefit plan for you, known as the SMH Health Care, Inc. Flexible Benefits Plan. The Flexible Benefits allows Employees to make choices about their benefits and gives you the opportunity to choose among several different options of medical & prescription coverage. These options encourage you to take steps to promote individual health and to eliminate unnecessary medical care. This document includes the summary plan description for both the medical plan and the Flexible Benefits Plan.

GENERAL INFORMATION

This revised Summary Plan Description (SPD) is effective on October 1, 2017.

Name of the Plan:	Sarasota Memorial Health Care System Health and Wellness Plan and SMH Health Care, Inc. Flexible Benefits Plan
Type of Plan:	Self-funded Welfare Plan providing health benefits and a Section 125/cafeteria plan.
Type of Administration:	Medical benefits: Contract administration with the Third Party Administrator. Flexible Spending Accounts: Administered by SMHCS
Group Number:	SMHFJ05
Plan Sponsor:	SMH Health Care, Inc. 1700 South Tamiami Trail Sarasota, FL 34239 (941) 917-6177
Plan Effective Date:	Sarasota Memorial Health Care System Health and Wellness Plan: June 26, 1989 (revised periodically since original inception) (latest revision October 1, 2017) SMH Health Care, Inc. Flexible Benefits Plan: January 1, 1988 (revised periodically since original inception) (latest revision January 1, 2017)
Employer Identification Number	59-2620159
Plan Renewal Date:	October 1
Plan Fiscal Year Ends:	September 30
Plan Year	Sarasota Memorial Health Care System Health and Wellness Plan: October 1 to September 30 SMH Health Care, Inc. Flexible Benefits Plan: January 1 to December 31
Third Party Administrator for Medical Benefits:	WEBTPA, Inc. 8500 Freeport Parkway South Suite 400 Irving, TX 75063 877-697-2299
Agent for Service of Legal Process:	Sarasota Memorial Health Care System
Effective Date of Coverage:	61st day of regular employment

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements - Employees

Eligible Employees may elect to begin coverage under the Plan on the 61st day of regular employment. Procedures for electing coverage are in the section titled Enrollment and Elections.

You are eligible for participation in the Plan if you are a regular full or part-time Employee, working at least 20 hours per week, or 40 hours per pay period. Your Dependents are eligible to participate in the Plan when you are eligible as a regular full or part-time Employee. Temporary or Per Diem Employees who work, on average over a year's time, 30 hours per week or more, may be eligible for benefit coverage for themselves and their eligible child dependents.

Employees who terminate employment and return within 90 days from the termination date will have coverage beginning on the date of re-employment.

Employees who terminate employment and return later than 90 days from the termination date will be treated as new Employees and will be eligible on the 61st day of re-employment.

Temporary Employees are not eligible to participate in the Plan unless they average 30 or more hours per week over a year's time. Temporary Employees who transfer to a regular full-time or part-time position (at least 40 hours per pay period) are eligible to participate in the Plan on the 61st day of regular full- or part-time employment.

An Employee Participant who is on active duty in military service of the armed forces of the United States will continue to be eligible for coverage at the same contribution rates as apply to active Employee Participants during the first 30 days of active service. Following the initial 30 days of active service, such Participants shall continue to be eligible for the remainder of the first 2 years of active service but shall be required to pay the same contribution rates as apply to Participants electing continued coverage under COBRA.

Eligibility Requirements - Retirees

Eligible Retirees may elect to begin Retiree Medical/RX coverage under the Plan on the first day following the termination of their coverage as an Employee.

You are eligible for Retiree Medical/RX coverage if you are any age with at least 30 years of service with SMHCS, or at least age 55 with at least 20 years of service with SMHCS and a total of 41,600 lifetime service hours.

Election to participate in Retiree Medical/RX coverage must be made within 60 days following the date of termination of Employee coverage.

Eligible Retirees are not eligible to participate in dental benefits, vision benefits, flexible spending account benefits or group life insurance benefits.

Eligibility Requirements - Dependents

For purposes of the medical benefits, an eligible Dependent of an Employee is:

- The Participant's legal spouse who is a resident of the same country in which the Participant resides. Such spouse must have met all requirements of a valid marriage contract in the state of marriage of such parties. The Participant may be required to provide satisfactory evidence of marriage.
- The Participant's child who meets **all** of the requirements listed below under "Eligibility Requirements – Children".

An eligible Dependent does not include:

- A spouse following final decree of dissolution or divorce
- Any person who is on active duty in military service
- Any person who resides outside of the United States
- Any person who is eligible and has enrolled as an Employee under the Plan
- Any person who is covered as a Dependent of another Employee under the Plan

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified. If you have a Dependent covered by the Plan who becomes ineligible under one of these categories, it is your responsibility to immediately notify Human Resources of this change. Failure to timely notify Human Resources may result in financial penalties to you and the Dependent.

Eligibility Requirements - Children

An eligible child of an Employee is any first generation child (excluding grandchildren, nieces, nephews, and any other child who has only an extended familial relationship to the Employee) who is listed below who is eligible for coverage based on his/her age group. A child is:

- The biological child of the Employee
- A stepchild of the Employee
- Placed for adoption in the residence of the Employee to the extent required by the laws of the State of Florida or by federal law (including Public Law 103-66)
- Under the legal guardianship of the Employee
- A foster child of the Employee for whom coverage is required by the laws of the State of Florida
- A child for whom the Employee is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Sponsor in accordance with its written procedures (which are incorporated herein for reference) to be a Qualified Medical Child Support Order (QMCSO). Upon receipt of an MCSO, the Plan Administrator will promptly inform the Employee, and each child who is the subject of the MCSO of its receipt of the order and will explain (in writing) the Plan's procedure for determining if the order is a Qualified Medical Child Support Order (QMCSO). Within a reasonable time, the Plan Administrator will decide whether the MCSO is qualified and will notify the Employee and the child(ren) of its determination. Coverage cannot be discontinued for any child who is enrolled to comply with a QMCSO unless the Employee submits written evidence that the child support order is no longer in effect.

In addition to the above, an eligible child will include a child for whom the Employee has received court appointed legal custody.

The Plan offers two types of coverage to children of eligible Employees, family coverage and extended over-age family coverage. A child's eligibility for either type of coverage depends on satisfaction of the eligibility criteria listed below for the age group within which the child falls:

Family Coverage

Family coverage is available to each Dependent child of a Covered Employee who is under age 26.

Extended Over-Age Family Coverage

Coverage for a child who meets the definition of "child" above, but who does not qualify for Family Coverage can be extended by separate non-family enrollment of the child if the child meets the following:

For children age 26 to 30 –

- The child is unmarried with no dependents of his/her own, and
- The child is either
  - A resident of the state of Florida, or
  - A full- or part-time student at an accredited school, college, university, vocational school or educational institution

The enrollment of any child separate from your family coverage will require payment of a separate premium for that child by you. Under current tax laws, the payment for over-age coverage cannot be made on a pre-tax basis through SMHCS's payroll system. Contact Human Resources to enroll the child and make arrangements for payment of these benefits for your over-age dependents. The cost of enrolling a child that qualifies for this extended over-age family coverage will be the COBRA cost that would apply to purchase single person coverage under COBRA.

Termination of Child's Coverage

Coverage based on status as a student will terminate at the end of the pay period following the last day of the semester, quarter or other term of study for which the child is enrolled. Coverage based on marital status, residence status or the child's status as having no other dependents of his/her own will end on the pay period following the last day that the child meets the criteria. In all other events, extended over-age family coverage will terminate on the last day of the calendar year in which the child meets the maximum age limit of eligibility listed above.

If you have a child covered by the Plan who ceases to be eligible under one of the above categories, it is your responsibility to immediately notify Human Resources of this change. Failure to timely notify Human Resources may result in financial penalties to you and the child.

If a child's coverage terminates after the child reached age 26, then the child will not be eligible to again be covered by the Plan as a Dependent child if the child has incurred more than a 63 day break in creditable coverage (from coverage under all types of plans for which creditable coverage is provided under the laws of the State of Florida).

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

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

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

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

1. begins while the child is suffering from a serious illness or Injury,
2. is medically necessary, and
3. causes the child to lose student status for purposes of coverage under the Plan.

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

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

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

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

Proof of Relationship is required to enroll all Dependents. Acceptable Proof of Relationship documents are:

- For All Dependents:
  First page of your most recent Federal Tax Return (Form 1040) listing the name and social security number of your spouse and/or all children you will enroll in this Plan (please black out all financial data). If this form lists all of the dependents you will enroll in this Plan, it is the only document you will need to provide to prove eligibility (the only exception to this is that you must also provide current school schedules for children age 26 to 30 who are not a resident of the state of Florida). Alternatively, you may provide:
- For spouse:
  - Marriage Certificate and two documents proving joint ownership. Acceptable documents proving joint ownership are: mortgage statements, credit card statements, bank statements, and leasing agreements listing both parties' names as co-owners. The joint ownership may be established prior to the current year; however the statement provided must be issued within the last three months.
- For children under age 26:
  - Birth Certificate
- For unmarried children age 26 and older:
  - Birth Certificate
  - Physician's Certification for disabled children (certifications are good for two years)

Social Security Numbers are required for all Dependents.

Effective Date - Dependents

Dependents who are eligible and enrolled concurrently with the Employee will be effective on the Employee's effective date. Except for a newborn, foster or adoptive child, a Dependent acquired later may become covered only if the Employee makes written application for coverage for the Dependent. If application is made:

- on or before the date the Dependent meets the eligibility requirements, the Dependent's coverage will be effective on the date of eligibility; or
- after the Dependent's date of eligibility but within 31 days of that date, the Dependent will become covered on the date of eligibility; or
- after 31 days beyond the date of eligibility, the Dependent's coverage will be effective only in accordance with the "Late Enrollment" or "Special Enrollment Rights" provisions.

A Dependent's coverage will NOT become effective prior to the Employee's coverage effective date.

Newborn Children - Limited Automatic 31-Day Benefit Period

If a Dependent child is born after the effective date of an Employee's coverage hereunder, benefits will be available for Eligible Expenses of the child which are incurred within the first 31 days after birth. Benefits for such child will be available for the 31-day period only (unless Employee has other Dependents enrolled in the Plan). After the 31-day period, coverage for the child will be available only if, within the 31 days after the child's birth, the Employee has notified the Plan Sponsor or the Contract Administrator of the birth, has enrolled the child, and has agreed to make any required contributions for coverage from the moment of birth.

NOTE: During the limited 31-day benefit period, a newborn child is NOT a Covered Person. Any extended coverage periods or coverage continuation options which are available to Covered Persons

WILL NOT APPLY to a newborn child who is provided with these 31 days of limited benefits and who is not enrolled within such 31-day period.

Adoptive Children

An adoptive child will be covered from the date the child is adopted by the Employee or the date he or she is placed with the Employee for adoption, provided the child is enrolled within thirty-one (31) days of adoption or placement for adoption. If the adoptive child is enrolled after thirty-one (31) days but within 60 days of the date of adoption or placement for adoption, the child may be enrolled but the Employee may be charged an additional contribution for the coverage of the child from the date of adoption or placement for adoption. If the child is not enrolled within this 60-day period, later enrollment will be subject to the "Late Enrollment" or "Special Enrollment Rights" provisions.

Foster Children

A foster child will be covered from the date the child is placed in the court-ordered temporary or other custody of the Employee if the Employee has elected coverage for other children. If the Employee has not elected coverage for other children, the coverage of the foster child will be subject to the "Special Enrollments Rights" provisions.

ENROLLMENT AND ELECTIONS

Enrollment

The timing of enrollment rules described in this Section limit your ability to initially enroll or make changes in your enrollment. There are special rules allowing or restricting mid-year changes in your enrollment elections in certain Change in Family Status or Special Enrollment Rights situations. If the general rule provides that you are not entitled to enroll or make a change until the next open enrollment date, any coverage changes you elect will not be effective until the first day of the following Plan Year (October 1 unless you qualify to make a change because of a Change in Family Status or Special Enrollment Rights situations).

After you satisfy the eligibility requirements, you become a Participant by enrolling in benefits on-line through eBenefits. You can make your benefit selections from home at www.smh.com or at work via the SMHCS intranet by accessing MyHR. An eligible Employee who fails to enroll will not be able to elect any benefits under the Plan until the next Open Enrollment Period (unless a "Change in Election Event" occurs or you have a Special Enrollment right).

On-line enrollment must be completed within the first 60 days of employment as a regular Employee. If on-line enrollment is not completed within the first 60 days of employment, you will not be enrolled in the medical benefits and will not be eligible to enroll until the next annual enrollment period, with an effective date of the following October 1. If on-line enrollment is not completed within the first 60 days of employment, you will not be enrolled in the flexible spending accounts and will not be eligible to enroll until the next annual enrollment period, with an effective date of the following January 1.

Change in Elections

You generally cannot change your election to participate in the Plan or vary the salary reduction amounts that you have selected during the Plan Year. This is known as the irrevocability rule. Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year. During the Plan Year, however, there are several important exceptions to the irrevocability rule.

The Plan Administrator may also reduce your salary reductions (and increase your taxable regular pay) during the Plan Year if you are a highly compensated individual as defined by the Internal Revenue Code ("the Code"), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law. Additionally, if a mistake is made as to your eligibility or

participation, the allocations made to your account, or the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate, or otherwise adjust such amounts as will in its judgment accord the credits to the account or distributions to which you are or such other person is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

Special Enrollment Rights

Under federal law, you have the right to enroll in the medical benefits offered under the Plan mid-year if you (1) decline coverage under this Plan for yourself or an eligible Dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons; (2) gain or lose eligibility under Medicaid or a state children's health insurance program; or (3) acquire a new Dependent.

Initial Declination Due to Other Coverage – An individual who did not enroll in the Plan when first eligible will be allowed to apply for medical coverage under the Plan at a later date if:

- he or she was covered under another group health plan or other health insurance program at the time coverage was initially offered;
- the individual lost the other coverage as a result of a certain event, such as loss of eligibility for coverage, expiration of COBRA continuation coverage, termination of employment or reduction in the number of hours of employment, or employer contributions towards such coverage were terminated; and
- the Employee requested Plan enrollment within thirty-one (31) days of termination of the other coverage.

If the above conditions are met, Plan coverage will be effective on the day of the event.

Special Enrollment Rights under SCHIP - An Employee who declined enrollment for himself or for an eligible Dependent while Medicaid coverage or coverage under a state children's health insurance program was in effect may be able to enroll himself and his Dependents in the medical coverage offered under the Plan if eligibility for that other coverage is lost. Application must be made within 60 days of the date that the Employee's or Dependents' coverage ends under Medicaid or the state children's health insurance program.

An Employee who declined enrollment for himself or for an eligible Dependent may be able to enroll himself and his Dependents in the medical coverage offered under the Plan if he or his Dependent becomes eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this Plan. Application must be made within 60 days of the date on which the Employee or Dependent is determined to be eligible for such assistance.

Entitlement Due to Acquiring New Dependent(s) – An Employee who declined to enroll in the Plan when first eligible or who declined to enroll his Dependents when first eligible will be allowed to apply for medical coverage under the Plan (for himself or for himself and his eligible Dependents) at a later date if one or more new eligible Dependents are acquired through marriage, birth, adoption, or placement for adoption (as defined by federal law). Application must be made within 31 days of the date the new Dependent or Dependents are acquired (the "triggering event"), and Plan coverage will be effective as follows:

- where Employee's marriage is the "triggering event" – on the day of the marriage;
- where birth, adoption, or placement for adoption is the "triggering event" – on the date of the event (i.e., concurrent with the child's date of birth, date of placement, or date of adoption).

Change in Family Status

Participants can change their elections under the Plan during a Plan Year if an event occurs that is a Change in Election Event and certain other conditions are met, as described below. Note that the Change in Election Events do not apply for all Benefits - applicable exclusions are described under the relevant headings. In addition, the Plan Administrator can change certain elections on its own initiative. Note also that no changes can be made with respect to Medical Plan Benefits if they are not permitted under the Medical Plan.

If any Change in Election Event occurs, you must log into MyHR and complete the family status request within 30 days after the occurrence. If the change involves a loss of your Spouse's or Dependent's eligibility for the Medical Plan, then the change will be deemed effective as of the date that eligibility is lost due to the occurrence of the Change in Election Event, even if you do not request it within 30 days.

Leaves of Absence. (Applies to Premium Payment Benefits and Dependent Care FSA Benefit, but not to Health FSA Benefits). You may change an election under the Plan upon FMLA and non-FMLA leave only as described in the Section titled Extension of Coverage Provisions.

Change in Status. (Applies to Premium Payment Benefits and to Dependent Care FSA Benefits, but not to Health FSA Benefits.) If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, or annulment);
- a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
- any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specific age, ceasing to be a student, or a similar circumstance); or
- a change in your, your Spouse's, or your Dependent's place of residence that results in a move into or out of the network area of the Medical Plan or other Benefit Option.

Change in Status—Other Requirements. (Applies to Premium Payment Benefits and Dependent Care FSA Benefits). If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for Dependent Care FSA Benefits, the event may also affect eligibility of Dependent Care Expenses for the dependent care tax exclusion).

In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

- Loss of Spouse or Dependent Eligibility. For accident and health benefits, a special rule governs which type of election changes is consistent with the Change in Status. For a Change in Status involving your divorce, or annulment from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce or annulment, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements might fail to correspond with that Change in Status.

- Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.
- Dependent Care FSA Benefits. With respect to the Dependent Care FSA Benefits, you may change or terminate your election with respect to a Change in Status event only if (a) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the Dependent Care FSA; or (b) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

Certain Judgments, Decrees, and Orders. (Applies to Premium Payment Benefits, but not to Health FSA Benefits or Dependent Care FSA Benefits). If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the Medical Plan, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

Medicare or Medicaid. (Applies to Premium Payment Benefits, but not to Health FSA Benefits or Dependent Care FSA Benefits). If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Medical Plan. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's coverage under the Medical Plan.

Change in Cost. (Applies to Premium Payment Benefits, and to Dependent Care FSA Benefits as Limited Below, but not to Health FSA Benefits). If the cost charged to you for your Medical Plan Benefits (or other Benefit Option) or Dependent Care FSA Benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefit package option provides similar coverage. For these purposes, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA; (2) an HMO and a PPO are considered to be similar coverage; (3) basic, comprehensive and extended coverage options are considered to be similar coverage under the Medical Plan; and (4) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

If the cost of Medical Plan Benefits (or other Benefit Option) or Dependent Care FSA Benefits significantly decreases during the Plan Year, then the Plan Administrator may permit the following election changes: (a) if you are enrolled in the benefit package option that has decreased in cost, you may make a corresponding decrease in your contributions; (b) if you are enrolled in another benefit package option (for example a certain coverage level under the Medical Plan), you may change your election on a prospective basis to elect the benefit package option that has decreased in cost; or (c) if you are otherwise eligible, you may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option.

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost.

The Plan Administrator generally will notify you of increases or decreases in the cost of Medical Plan Benefits; you generally will have to notify the Plan Administrator of increases or decreases in the cost of Dependent Care FSA benefits.

The change in cost provision applies to Dependent Care FSA Benefits only if the cost change is imposed by a dependent care provider who is not your relative.

Change in Coverage. (Applies to Premium Payment Benefits and Dependent Care FSA Benefits, but not to Health FSA Benefits). You may also change your election if one of the following events occurs:

- Significant Curtailment of Coverage. If your Medical Plan Benefits (or other Benefit Option) or Dependent Care FSA Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Plan), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally - loss of one particular physician in a network does not constitute significant curtailment). If your Medical Plan Benefits or Dependent Care FSA Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Medical Plan coverage; you generally will have to notify the Plan Administrator of significant curtailments in Dependent Care FSA Benefits coverage).
- Addition or Significant Improvement of Plan Option. If the Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.
- Loss of Other Group Health Coverage. You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
- Change in Election Under Another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Plan permits you to make an election

for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan, which it does. For example, if an election to drop coverage is made by your Spouse during his or her employer's open enrollment, you may add coverage under the Plan to replace the dropped coverage.

- Dependent Care FSA Coverage Changes. You may make a prospective election change that is on account of and corresponds with a change by your dependent care service provider. For example: (a) if you terminate one dependent care service provider and hire a new dependent care service provider, then you may change coverage to reflect the cost of the new service provider; and (b) if you terminate a dependent care service provider because a relative becomes available to take care of the child at no charge, then you may cancel coverage.
- Employee is eligible for and intends to enroll in a Qualified Health Plan through a Marketplace/Exchange, either in a Special Enrollment Period or in the regular Open Enrollment Period in the Marketplace.

Reinstatement Following Leave of Absence

If an Employee returns to regular employment and eligible status following an approved leave-of-absence in accordance with the Employer's guidelines, and during the leave the Employee discontinued paying his share of the cost of coverage, causing coverage to be suspended, then upon return from leave, the outstanding balance will be withheld from the Employee's compensation and coverage will continue without interruption.

In accordance with federal law, certain Employees who return to employment following active duty service as a member of the United States Reserves or National Guard will be reinstated to coverage under the Plan (for themselves and any Dependents who were covered prior to the military assignment). The waiting period requirement does not apply. However, this provision is intended to comply with the minimum requirements of the Veteran's Re-Employment Rights Law, and if it is in conflict or incomplete in any way, such law will prevail.

Transfer of Coverage

If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

PAYING FOR BENEFITS

Paying for Benefits on a Pre-Tax Basis

An employee's election to pay for benefits on a pre-tax basis is made by entering into an agreement with the employer when electing benefits. Under that agreement, when you elect certain benefits, you elect to pay for those benefits on a pre-tax basis, that is, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. You will then pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis.

Tax Savings

You may save both federal income tax and FICA (Social Security) taxes by participating in the Plan. Here is an example of the possible tax savings of paying for your share of the contributions for the Medical Plan under this Plan. Suppose that you are married and have one child and that your share of the required contributions for Medical Insurance Benefits for family coverage is an annual total of

$6,400. Suppose also that your gross pay is $75,000 and your Spouse (a student) earns no income and that you file a joint tax return.

As illustrated in detail by the Table below, when you salary-reduce $6,400 to pay for the Medical Plan contributions, then your annual take-home pay would be $57,249. In contrast, if you were to pay the contributions on an after-tax basis, then your annual take-home pay would be only $55,799. This is because by paying your Medical Plan contributions under this Plan, you will be considered for tax purposes to have received $68,600 in gross pay (instead of $75,000), so you save $1,450 per year. How much an employee actually saves will depend on what family members are covered and the contributions for the coverage, the total family income, and the tax deductions and exemptions claimed. Salary reductions also lower earned income, which can impact the earned income credit for eligible taxpayers.
Caution: The amount of the contributions used in this example is not meant to reflect your actual contributions—the actual contribution amounts will be described in documents provided separately to you by the Employer.

	Cafeteria Plan	No Cafeteria Plan
1. Adjusted Gross Income	$75,000	$75,000
2. Salary Reductions for Premiums	($6,400)	$0
3. W-2 Gross Wages	$68,600	$75,000
4. Standard Deduction	($11,400)	($11,400)
5. Exemptions	($10,950)	($10,950)
6. Taxable Income (line 3 minus lines 4 & 5)	$46,250	$52,650
7. Federal Income Tax (line 6 @ tax schedule)	($6,103)	($7,063)
8. FICA Tax (7.65% of line 3)	($5,248)	($5,738)
9. After-Tax Premium Payments	$0	($6,400)
10. Pay After Taxes and Premium Payments (line 3 minus lines 8, 9 & 10)	$57,249	$55,799

MEDICAL PLAN

Covered Employees, Retirees, and Dependents participating in the SMHCS Health and Wellness Plan have a choice of three Plan options – Comprehensive Plan, Basic Plan, and Extended Plan. Participants who elect coverage under the Comprehensive or Basic Plans will receive services from providers participating in the Gulf Coast Select Network. Basic Plan Members must have a referral to see a specialist; Comprehensive Plan Members must have a referral after 2 visits to a specialist. You do not need a referral in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures including obtaining pre-authorization for certain services or following a pre-approved treatment plan. You also do not need a referral for an out of area child receiving services within the First Health Network.

Comprehensive Plan Members and Basic Plan Members ***must*** select a Primary Care Physician (PCP) from the list of active Gulf Coast Select Providers. (See Schedule of Medical Benefits for additional details). You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For covered children, you may designate a pediatrician as the primary care provider.

Covered Employees and Dependents in the Comprehensive and Basic Plans must use SMHCS facilities and Gulf Coast Select Providers, unless they are an Out-Of-Area Child. Out-Of-Area Children seeking non-emergency treatment when outside of the Gulf Coast Select Provider network service area must utilize the First Health network. There is no out-of-area coverage for Comprehensive and Basic Plan Members and Dependents unless it is a true medical Emergency.

Participants who elect coverage under the Extended Plan will receive services from providers participating in the Gulf Coast Provider Network. The Gulf Coast Provider Network covers Sarasota and Manatee Counties Residents in these counties must use the Gulf Coast Provider Network in order to obtain in-network (maximum) benefits. Covered Employees, Retirees and Dependents covered under the Extended Plan who are residing outside the noted two county areas may access the First Health Network for in-network services. Members residing in the Gulf Coast Provider Network service area may not access First Health Network providers unless urgent or emergency care is needed while the Member is temporarily traveling out of the service area. First Health claims incurred within the Gulf Coast Network service area shall be considered Out-of-Network.

Out-Of-Network Providers will be paid the same as Network Providers in the following circumstances only:

- Emergency Care – if a Covered Person requires Emergency care (i.e., care for a condition which, if not treated immediately could lead to disability or death) and must use the services of an Out-of-Network Facility;
- Unavailable Services – if a Covered Person must use the services of an Out-Of-Network Provider specialist because the necessary specialty is not represented in the Network. (Pre-certification by Medical Management required);
- Due to the nature of Emergencies, if you seek treatment for an Emergency at a Facility or from a Provider that is not in-Network within the 2 county areas (Sarasota & Manatee) because the Out-Of-Network Facility or Provider is closer than an in-network Facility or Provider, your coverage will provide Network benefits.

Participating Providers are located on Gulf Coast Provider website (www.gulfcoastprovider.net). For additional information call 941-917-4004.

SCHEDULE OF MEDICAL BENEFITS

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Deductible* – Individual/Family – SMHCS Facility	$0/$0	$250/$1,500	$0/$0	
Deductible* – Individual/Family – Non-SMHCS facility	N/A	N/A	$1,500/ $4,500	$2,500/ $8,500
Out-of Network Hospital Deductible* (In addition to the above deductible) – Individual/Family	N/A	N/A	N/A	$1,000
Children out of the 2 county area deductible* # (First Health Network must be used for In-Network benefits)	$1,000	$1,000	$1,500	$2,500
* The deductible applies to the Plan Year; as of the beginning of each Plan Year, the deductible limit will be reset for all Covered Employees and Dependents # Out of area children must use the First Health Network to receive coverage at the In Network levels after satisfying deductible.				
Co-insurance SMHCS	85/15	80/20 (Subject to deductible)	85/15	N/A
Co-insurance Non-SMHCS	N/A	N/A	60/40 (Subject to deductible)	40/60 (Subject to deductible)
Co-insurance Out-of Area Children	80/20 (Subject to deductible)	80/20 (Subject to deductible)	60/40 (Subject to deductible)	40/60 (Subject to deductible)
Maximum Medical Out of Pocket (Co-insurance limits) – Individual/Family	$1,500/$4,500 (does not include deductibles, co-pay)	$2,500/$7,500 (does not include deductibles, co-pay)	$6,350/ $12,700 (includes deductibles, co-pay)	Unlimited
Maximum Medical Out of Pocket (Essential Health Benefits, Med and Rx combined) – Individual/Family	$6,600/$13,200 Includes Deductibles and Co-Pays	$6,600/$13,200 Includes Deductibles and Co-Pays		Unlimited
Provider Office Visits				
PCP Office Visit	Initial plan yr visit free, then $25Co-pay	Initial plan yr visit free, then $25Co-pay	Initial plan yr visit free, then $25Co-pay	$25 Co-pay (Subject to deductible)

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Specialist Office Visit	$50 Co-pay PCP referral required after 2 Specialist (same type) visits per Plan Year. 5 visits per year to Dermatologist without referral. No referral needed for Podiatrist or OB/GYN.	$50 Co-pay PCP referral required for each Specialist visit. 5 visits per Plan Year to Dermatologist without referral. No referral needed for Podiatrist or OB/GYN.	$50 Co-pay	$50 Co-pay (Subject to deductible)
Holistic Care (Chiropractic (excludes massage therapy), Acupuncture, Herbal Medicine) (Combined benefit)	$50 Co-pay 15 visits or $600 limit per Plan Year, whichever is less	No Coverage	$50 Co-pay 15 visits or $600 limit per Plan Year, whichever is less	40/60 (Subject to deductible) 15 visits or $600 limit per Plan Year, whichever is less
Maternity				
Pre/post natal care and Hospital Services processed accordingly	$50 Co-pay/Initial Visit 85/15	$50 Co-pay/Initial Visit 80/20	$50 Co-pay/Initial Visit 85/15 (SMHCS) 60/40 (In-network-non SMHCS) (Subject to deductible)	40/60 (Subject to deductible) Initial Visit
Hospital	85/15 (SMHCS only)	80/20 (SMHCS only) (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Breastfeeding support, supplies and counseling, manual or electric breast pumps purchased or rented	100% up to a tri-annual maximum of $250	100% up to a tri-annual maximum of $250	100% up to a tri-annual maximum of $250	100% up to a tri-annual maximum of $250

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Facilities & Services				
Urgent Care Facility (Facility and Physician combined).	$30 Co-pay (Co-pay waived if sent to and treated in Emergency Room) 85/15 Charges billed separately for lab, x-ray, injections, medicines, vaccine administration, procedures, durable medical equipment Services covered at any Urgent Care Facilities outside of the Manatee and Sarasota counties. Within Manatee and Sarasota counties, services covered only at SMH facilities.	$30 Co-pay (Co-pay waived if sent to and treated in Emergency Room) 80/20 Charges billed separately for lab, x-ray, injections, medicines, vaccine administration, procedures, durable medical equipment Services covered at any Urgent Care Facilities outside of the Manatee and Sarasota counties. Within Manatee and Sarasota counties, services covered only at SMH facilities.	$30 Co-pay (Co-pay waived if sent to and treated in Emergency Room) 85/15 (SMHCS) 60/40 (In-network, non- SMHCS) (Subject to deductible) Charges billed separately for lab, x-ray, injections, medicines, vaccine administration, procedures, durable medical equipment	$30 Co-pay (Co-pay waived if sent to and treated in Emergency Room) 40/60 (Subject to deductible) Charges billed separately for lab, x-ray, injections, medicines, vaccine administration, procedures, durable medical equipment
Emergency Room Emergency Only	$200 Co-pay, Co-pay waived if admitted	$200 Co-pay, Co-pay waived if admitted	$200 Co-pay, Co-pay waived if admitted	
Genetic Testing (As provided in item #14 of Covered Medical Expenses)	$500 Co-pay	$500 Co-pay	$500 Co-pay (SMHCS only)	Not covered
Hospital – Inpatient (Additional $1,500 Co-pay for Weight Loss/Bariatric Surgery. Covered only when performed at SMHCS Bariatric Center.)	85/15 (SMHCS only)	80/20 (SMHCS only) (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Physician Charges – Inpatient	85/15	80/20 (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non- SMHCS facilities) (Subject to deductible)	40/60 (Subject to deductible)
Outpatient Surgery	85/15 (SMHCS only)	80/20 (SMHCS only) (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non- SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Physician Charges – Outpatient Surgery	85/15	80/20 (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non- SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Skilled Nursing Facility Maximum 90 days per year, if not at SMHCS Facilities.	85/15 (SMHCS only)	80/20 (SMHCS only) (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Preadmission Testing	85/15 (SMHCS only)	80/20 (SMHCS only) (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
2nd Opinion	60/40	Not Covered	60/40	40/60 (Subject to deductible)
Contraception/Family Planning				
Tubal Ligation/ Vasectomy	100%	100%	100% (SMHCS)	40/60 (Subject to deductible)
Birth Control Pills	Covered as a Prescription Drug	Covered as a Prescription Drug	Covered as a Prescription Drug	
IUD, Diaphragm, cervical caps	100% of FDA approved contraceptive methods that are considered Preventive Services	100% of FDA approved contraceptive methods that are considered Preventive Services	100% of FDA approved contraceptive methods that are considered Preventive Services	Not Covered

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Tubal Ligation Reversal/Vasectomy Reversal	Not Covered	Not Covered	Not Covered	
Infertility Treatment, Artificial Insemination, Surrogate Mother, In-Vitro Fertilization, etc.	Not Covered	Not Covered	Not Covered	
Well Care – Child				
Newborn Well Care (inpatient)	Preventive Services covered at 100%; other services covered at 85/15 (SMHCS only)	Preventive Services covered at 100%; other services covered at 80/20 (SMHCS only) (Subject to deductible)	Preventive Services covered at 100%; other services covered at 85/15 (SMHCS) Preventive Services covered at 100%; other services covered at 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Well Child Care – periodic examinations at the following intervals of age: *2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, annually ages 3 – 17*	Preventive Services covered at 100%; other services covered at 85/15	Preventive Services covered at 100%; other services covered at 80/20 (Subject to deductible)	Preventive Services covered at 100%; other services covered at 85/15 Preventive Services covered at 100%; other services covered 60/40 (In-network non-SMHCS) (subject to deductible)	Not Covered

Benefit	**Comprehensive Plan**	**Basic Plan**	**Extended Plan**	
	In Network	**In Network**	**In Network**	**Out of Network**
Well Care – Adult	Preventive Services covered at 100%; other services covered at 85/15	Preventive Services covered at 100%; other services covered at 80/20	Preventive Services covered at 100%; other services covered at 85/15 (SMHCS) Preventive Services covered at 100%; other services covered 60/40 (In-network non-SMHCS) (subject to deductible)	Not Covered
Routine Physical	Preventive Services covered at 100%; other services covered 85/15	Preventive Services covered at 100%; other services covered 80/20 (subject to deductible)	Preventive Services covered at 100%; other services covered 85/15 (SMHCS) Preventive Services covered at 100%; other services covered 60/40 (In-network non-SMHCS) (subject to deductible)	40/60 (subject to deductible)
Annual Well Woman/Pap Smear	Preventive Services covered at 100%; other services covered 85/15	Preventive Services covered at 100%; other services covered 80/20 (subject to deductible)	Preventive Services covered at 100%; other services covered 85/15 (SMHCS) Preventive Services covered at 100%; other services covered 60/40 (In-network non-SMHCS) (subject to deductible)	40/60 (subject to deductible)

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Mammogram (including 3-D mammogram)	Preventive Services covered at 100%; other services covered 85/15	Preventive Services covered at 100%; other services covered 80/20 (subject to deductible)	Preventive Services covered at 100%; other services covered 85/15 (SMHCS) Preventive Services covered at 100%; other services covered 60/40 (In-network non-SMHCS) (subject to deductible)	40/60 (subject to deductible)
Wellness & Educational Programs				
SMHCS Coumadin Clinic	100%	100%	100%	Not Covered
SMHCS Heart Failure Clinic	100%	100%	100%	Not Covered
SMHCS Diabetes Treatment Program	100%	100%	100%	Not Covered
Diagnostic Labs				
CT Scans/MRI/Diagnos-tic X-rays & Labs (Pre-authorization needed if a surgical procedure is involved)	85/15 (SMHCS only)	80/20 (SMHCS only) (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non- SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Physician charge to read labs/x-rays	85/15	80/20 (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non- SMHCS facilities) (Subject to deductible)	40/60 (Subject to deductible)
Other				
Ambulance (Ground & Air)	85/15	85/15	85/15	85/15
Allergy Serums & Injections	85/15	80/20 (Subject to deductible)	60/40 (Subject to deductible)	40/60 (Subject to deductible)

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
TMJ - Diagnostic procedures and surgical procedures to treat conditions caused by a congenital or developmental deformity, disease or Injury	85/15 (SMHCS only)	80/20 (SMHCS only) (Subject to deductible)	85/15 (SMHCS) 60/40 (In-network, non-SMHCS facilities) (Subject to deductible)	40/60 (Subject to deductible)
TMJ – (1) Non-diagnostic and non-surgical procedures (2) Diagnostic and surgical procedures for conditions that are not caused by a congenital or developmental deformity, disease or Injury	85/15 (SMHCS only) $1,000 lifetime maximum	Not Covered	85/15 (SMHCS) 60/40 (In-network, non-SMHCS facilities) (Subject to deductible) $2,500 lifetime maximum	40/60 (Subject to deductible) $2,500 lifetime maximum
Organ Transplants (subject to pre-authorization)	100% of Eligible Charges in network 90% of eligible charges, up to varying maximums, defined on page 47	100% of Eligible Charges in network 90% of eligible charges, up to varying maximums, defined on page 47	100% of Eligible Charges in network	90% of eligible charges, up to varying maximums, defined on page 47
Durable Medical Equipment	80/20 **Pre-Cert needed, if over $500**	Not Covered	60/40 (In-network) (Subject to deductible) **Pre-Cert needed, if over $500**	40/60 (Subject to deductible) **Pre-Cert needed, if over $500**
Home Health	85/15 (SMHCS) 60 visits per year	$25 Co-pay 30 visits per year (In lieu of hospitalization, requires Medical Management Approval)	85/15 (SMHCS) 60/40 (In-network, non- SMHCS) (Subject to deductible) 60 visits per year	40/60 (Subject to deductible) 60 visits per year

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Hospice	100% 60 day lifetime maximum	100% 60 day lifetime maximum	100% 60 day lifetime maximum	40/60 (Subject to deductible) 60 day lifetime maximum
Infusion	100% at SMHCS with no pre-authorization 85/15 with pre-authorization for other network facilities	100% at SMHCS with no pre-authorization 80/20 with pre-authorization for other network facilities	100% at SMHCS with no pre-authorization 60/40 with pre-authorization (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible) Pre-authorization required
Physical Therapy/Speech Therapy/ Occupational Therapy (Therapy limited to a combined maximum of 30 visits per year, with the exception of post joint replacement therapy, with pre-authorization of Medical Management)	$25 Co-pay	$25 Co-pay 30 visits per year (Only if hospitalization would otherwise be required; requires Medical Management Approval)	$25 Co-pay	$25 Co-pay
Massage Therapy* (Therapy limited to a maximum of 30 visits per year)	$25 Co-pay (requires a doctor's prescription)	$25 Co-pay (requires a doctor's prescription and Medical Management Approval)	$25 Co-pay (requires a doctor's prescription)	$25 Co-pay

*****Massage Therapy only covered at the SMH HealthFit facility at 5880 Rand Boulevard or at the main SMH campus in Sarasota, FL. OOA Students and Extended Plan members have open access outside of the Sarasota Area for massage therapy, but massage therapy rendered in the Sarasota area will only be allowed at SMH/HealthFit.

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Behavioral Health/Substance Abuse (GCPNS = Gulf Coast Provider Network Select)				
After the second visit, non-emergency behavioral health and/or substance abuse treatment must be pre-authorized with a GCPNS provider by EAP. With a change in level of care a new pre-authorization is required.				
Mental – Inpatient	85/15	85/15	85/15 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Mental – Outpatient Pine Tree Counseling Center located at: 1515 S. Osprey Avenue, Suite C-12 Sarasota, Florida Corner of Floyd Street and Osprey Avenue	EAP – Up to 6 counseling sessions per year 100% Co-pay waived at Pine Tree Counseling Center at EAP Sarasota $25 Co-pay in GCPNS[1] $50 Co-pay for psychiatrist in GCPNS[1]only No annual limit on number of visits	EAP – Up to 6 counseling sessions per year 100%, Co-pay waived at Pine Tree Counseling Center at EAP Sarasota $25 Co-pay in GCPNS[1] $50 Co-pay for psychiatrist in GCPNS[1] only No annual limit on number of visits	EAP – Up to 6 counseling sessions per year 100%, Co-pay waived at Pine Tree Counseling Center at EAP Sarasota 50/50 (In-network, non-SMHCS providers) (Subject to deductible) No annual limit on number of visits	40/60 (Subject to deductible)
Mental/Nervous – Outpatient/ Partial Day Facility Care	85/15 Co-pay waived if following Inpatient Stay at SMHCS Bayside	80/20 Co-pay waived if following Inpatient Stay at SMHCS Bayside	85/15 Co-pay waived if following Inpatient Stay at SMHCS Bayside 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)
Substance Abuse – Inpatient/ Detoxification	85/15	Not Covered	85/15 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)

[1] Gulf Coast Provider Network Select

Benefit	Comprehensive Plan	Basic Plan	Extended Plan	
	In Network	In Network	In Network	Out of Network
Substance Abuse – Outpatient	Co-pay waived at Pine Tree Counseling Center at EAP Sarasota $25 Co-pay in GCPNS[1] $50 Co-pay for psychiatrist in GCPNS[1] only No annual limit on number of visits	Not Covered	Co-pay waived at Pine Tree Counseling Center at EAP Sarasota 50/50 (In-network, non-SMHCS) (Subject to deductible) No annual limit on number of visits	40/60 (Subject to deductible)
Substance Abuse - Partial Day Facility Care	85/15 Co-pay waived if following In-Patient Stay at SMHCS Bayside	Not Covered	85/15 60/40 (In-network, non-SMHCS) (Subject to deductible)	40/60 (Subject to deductible)

[1] Gulf Coast Provider Network Select

PRE-AUTHORIZATION REQUIREMENTS

General Information
All non-emergency procedures greater than $1,000 require Pre-Authorization and must be done at an SMHCS facility if clinically appropriate.

You are responsible to ensure that you or your provider obtains pre-authorization for all:

- Hospital admissions due to emergencies within 48 hours of admission (72 hours on weekends and holidays)
- Observations over 23 hours
- Outpatient surgeries and invasive procedures
- Office procedures and office diagnostics over $1,000, except for Dermatology procedures and Allergy serums
- Dental extractions other than wisdom teeth
- Mental health services

Failure to obtain pre-authorization for the above services will result in reduced benefits. **To obtain pre-authorizations, you must work with the provider to place authorization at www.gulfcoastmemberservices.org. For mental health or substance abuse pre-authorizations, see Mental Health Pre-authorization section below.**

Hospitalizations
A Participant, a member of his or her family, or his Physician must notify WEBTPA prior to any non-emergency hospitalization. In the event of an emergency hospitalization, the Participant, a member of his or her family or his Physician must notify WEBTPA within forty-eight (48) hours or on the first business day following admission. **For maternity admissions, the attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.**

Upon notification, WEBTPA will review the Participant's condition and proposed treatment plan and will work with the attending Physician to plan the hospitalization in advance. A Participant's confinement is subject to concurrent review to ensure that the Participant has a clear need to remain hospitalized and to document any complications requiring a longer confinement than expected.

Penalty for Non-Compliance
Failure to follow the above-specified notification procedures will result in no benefits payable for the hospitalization, out-patient services, and related expenses. The provider has a right to appeal this process by providing clinical documentation to the Medical Management Department and if this service is found to be medically necessary the maximum benefit provided will be 50%. Additional costs paid by the Participant due to this reduction in benefits will not apply to the accumulation of the Out-of-Pocket Medical Maximum for Members in the Basic and Comprehensive Plans.

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact **WEBTPA at 877-697-2299** to make certain that the Hospital or attending Physician has initiated the necessary processes.

Also, pre-authorization **is not** a guarantee of coverage. The **Medical Management Program** is designed ONLY to determine whether or not a proposed course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions.

Outpatient and Diagnostic Procedures Requiring Pre-Authorization

Prior to undergoing any outpatient surgery, invasive procedure, or office procedure over $1,000, a Covered Person or his attending Physician must request pre-authorization from **Gulf Coast Medical Management at www.gulfcoastmemberservices.org. The following lists examples of procedures that must have pre-authorizations. This list is not all inclusive and if you are having any procedure performed that is not listed below that would be considered to be outpatient surgery, you or your physician should call WEBTPA to have it pre-authorized.**

- Abdominoplasty
- Arthroscopy (any type)
- Back Surgery (i.e., Laminectomy, Diskectomy, Fusion)
- Biopsy
- Breast Surgery
- Bronchoscopies
- Cardiac Caths
- Carpal Tunnel
- Cardiac Rehabilitation (more than 8 weeks)
- Cardioversion
- Cholecysectomy
- Clinical Trials
- Colonoscopies
- EGD's
- Endoscopies
- ERCP's
- Genetic Testing
- Growth Hormone Therapy
- Hernia
- Home Health Care
- Hysterectomy
- Infusion outside of an SMHCS facility
- Jaw Surgery (i.e., TMJ, LaForte Osteotomies)
- J Codes in office over $500
- Laparoscopy
- Lysis of Adhesions
- Nasal Surgery (i.e., Septoplasty, Rhinoplasty, SMR)
- Observation services over 23 hours
- PET Scans (any type)
- Sigmoidoscopies
- Substance Abuse Treatment
- Tonsillectomy/Adenoidectomy
- Weight Loss Surgery

Integrated Case Management

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- Personal support to the patient;
- Contacting the family to offer assistance and support;
- Monitoring Hospital or Skilled Nursing Facility;
- Determining alternative care options; and

- Assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

The Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Mental Health Pre-Authorization

EAP is Sarasota Memorial's starting point for behavioral health and substance abuse treatments under the Comprehensive, Basic, and Extended Medical Plans. Prior to seeking non-emergency mental health or substance abuse treatment, Members are encouraged to contact EAP for pre-authorization. Contacting EAP may benefit you with referrals to reputable treatment professionals, and earlier coordination between treatment professionals and the Plan may help that treatment professional devise a treatment plan that complies with applicable guidelines and avoid delays in Plan payments or reimbursements. Network providers can be located at www.gulfcoastprovider.net.

The Plan requires pre-authorization from EAP for behavioral health and substance abuse hospitalization in order to receive full benefits. **To obtain pre-authorizations, choose a provider at www.gulfcoastmemberservices.org and contact EAP Sarasota at 941-917-1240.**

In addition,

Basic Plan Members must have pre-authorization from EAP to see a mental health provider for behavioral health (substance abuse treatment is not covered under the Basic Plan).

Comprehensive Plan Members must have pre-authorization from EAP after 2 visits per plan year to a see a mental health provider for behavioral health or substance abuse.

Extended Plan Members do not need pre-authorization from EAP to see an outpatient mental health provider for behavioral health or substance abuse. However, pre-authorization is needed for inpatient or partial day care treatment.

Failure to obtain pre-authorization for behavioral health and/or substance abuse treatment will result in denial of payment by SMHCS and the Member will be held responsible for payment.

EAP Sarasota
1515 South Osprey Avenue
Suite C-12
Sarasota, FL 34239
941-917-1240
800-425-7764

In the event of an emergency, Members should seek treatment and notify EAP within 48 hours or as soon as possible.

MEDICAL PLAN COVERED SERVICES

The Plan provides coverage for a wide range of services called **Covered Services.** The services associated with this benefit are covered to the extent that they are:

1. Medically Necessary;
2. Prescribed by or given by a Physician; and
3. Provided for care and treatment of a covered illness or Injury.

Benefits are payable in accordance with the applicable benefit percentages listed in the **Schedule of Medical Benefits.**

Covered Services
Covered services are the services listed below, subject to the **Definitions, General Limitations,** and all other provisions of this Plan:

1. **Ambulance Service:** Ambulance transportation, as shown in the **Schedule of Medical Benefits,** in a ground vehicle, fixed wing aircraft, or rotary wing aircraft that is equipped as an ambulance and certified by the state in which it is used, and is staffed by at least two (2) medically trained allied health professionals from a Hospital to:
   - another Hospital;
   - a Skilled Nursing Facility;
   - a Covered Person's home.

   Ambulance transportation from home or the place of an accident or medical emergency to the nearest Hospital that can provide the necessary level of care, even if that Hospital is out of the local area.

   NOTE: Air ambulance will only be covered to the same extent as a ground vehicle, unless the pickup point is inaccessible by land vehicle, speed is critical, or great distances are involved in getting the patient to the nearest Hospital with the appropriate facilities. In no case will benefits exceed the maximum specified in the **Schedule of Medical Benefits.** Newborns will be transported to the nearest facility able to treat their condition.

2. **Anesthetics:** Anesthesia, including intravenous, inhalation, intraspinal, and caudal anesthesia services for surgical or obstetrical procedures if the anesthesia is not administered by the Physician in charge of the case or administered by the Physician's partner or associate.

3. **Blood and Blood Derivatives:** Blood transfusion services, including the cost of blood, blood plasma and other blood products not donated or replaced by a blood bank or otherwise.

4. **Chiropractic Care:** Chiropractic treatment, up to the maximum specified in the **Schedule of Medical Benefits,** for the services of a licensed chiropractor (D.C.) for the treatment of a musculoskeletal disorder (bone, muscle, tendon and joint) and for related diagnostic x-rays performed and billed by the chiropractor. Excludes massage therapy, even if performed in a chiropractic office.

5. **Chemical Dependency/Alcoholism Treatment:**
   Treatment of Chemical Dependency/Alcoholism, up to any maximums specified in the **Schedule of Medical Benefits**. Care must be pre-authorized through EAP.

6. **Concurrent Care:** Hospital visits by more than one Physician when the Physicians are of different specialties or sub-specialties or are actively participating in managing the patient's care, provided the condition:
   - involves more than one body system; or
   - is so severe or complex as to preclude the expectation that one Physician would ordinarily be able to handle the patient's care alone.

7. **Consultations:** Consultations**,** provided the Physician in charge requests a consultation and the consulting Physician incorporates a written report into the patient's Hospital record.

8. **Cosmetic/Reconstructive Surgery:** Cosmetic/reconstructive surgery, only if such surgery is to restore normal bodily function lost as a result of:
   - Illness;
   - Accidental Injury occurring while covered under this Plan;
   - Congenital anomaly in a child who was covered under this Plan from birth; or
   - A previous surgical procedure that occurred while covered under this Plan.

   Coverage for breast reconstruction (including nipple tattoo when applicable) in connection with mastectomy will be provided in a manner determined in consultation with the attending Physician and the patient, for:
   - All stages of reconstruction of the breast on which the mastectomy was performed;
   - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
   - prostheses; and
   - Treatment of physical complications of the mastectomy, including lymphedema.

   These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under this Plan.

9. **Dental Care:** Dental care, treatment, or x-rays for impacted teeth, a fractured jaw, or necessitated as the direct result of an accidental Injury to sound natural teeth which have been damaged, or a fractured or dislocated jaw which requires setting. All services must be rendered within ninety (90) days of the accident and require pre-authorization.

10. **Diabetic Supplies:** Supplies for the condition of diabetes, including insulin, syringes, and clinitabs are covered under the Prescription Drug Program.

11. **Diagnostic X-Ray and Laboratory Services:** Diagnostic x-ray and laboratory services when performed for diagnostic studies of an illness or Injury, or in conjunction with surgical care.

12. **Durable Medical Equipment:** Rental, not to exceed the purchase price of a Hospital bed, wheelchairs, crutches, oxygen equipment, and similar Durable Medical Equipment, as shown in the **Schedule of Medical Benefits**. Insulin pumps are also covered as Durable Medical Equipment.

13. **Emergency Room Services:** Those services necessary to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part; or such other definition as may be required by applicable law.

14. **Experimental or Investigational:** Services or supplies, including surgery, transplants and drugs, which are Experimental or not provided in accordance with accepted professional medical standards in the United States, including research activities will not be covered. Charges which are Experimental or Investigational or for research, or charges for services and supplies which are not in accord with generally accepted professional medical standards or with the generally accepted methods of treatment are also not covered.
Participation in clinical trials will be covered with the following conditions and clarifications:
    (1) The clinical trial must be an approved trial for the treatment of cancer or another life-threatening condition.
    (2) The referring physician must be a Participating Provider in the clinical study
    (3) The covered patient must provide medical and scientific information establishing that their participation in the clinical trial is appropriate and they must provide documentation that they have been approved for participation in the clinical trial.
    (4) Routine patient services related to the clinical study will be covered but only if they are approved services under the health plan design. The member is still responsible for their cost sharing portion of covered services.

15. **Genetic Testing for Heredity Cancer Syndromes:** All individuals undergoing genetic testing for hereditary cancer syndromes (including hereditary breast and ovarian cancer syndrome) must receive appropriate pre- and post- test genetic counseling by the Medical Directors of Sarasota Memorial Health Care System's Genetic Education Program or a genetic counselor, nurse practitioner, physician assistant, or Physician practicing under his/her supervision. The charge for the counseling is generally not a covered benefit. Genetic testing for heredity cancer syndrome is covered only if, following the required counseling, such testing is deemed appropriate for the employee. Genetic counseling for BRCA genetic testing will be covered if the woman is referred by her healthcare provider with a statement from her provider stating she is at a "higher risk" for breast cancer based on personal and/or family history.

    Genetic testing for hereditary cancer syndromes is NOT considered a covered benefit when ordered outside of the supervision of the Medical Directors of Sarasota Memorial Health Care System's Genetic Education Program.
    Full information regarding the counseling and criteria for testing is available from the Sarasota Memorial Health Care System's Genetic Education Program at (941) 917-2005.

16. **Home Health Care:** Services of a Home Health Care Agency, up to two (2) hours per day, to the maximum indicated in the **Schedule of Medical Benefits,** for services furnished to a Covered Person in the home in accordance with a home health care plan, provided the following conditions are met:
    - The Covered Person is confined in a Hospital for at least three (3) consecutive days immediately prior to discharge (not counting the day of discharge), and the home health care is for further treatment of a condition which was treated in a Hospital or Skilled Nursing Facility;
    - A Physician determines the need for home health care and sets up a home health care plan prior to discharge from a Hospital or Skilled Nursing Facility, and the initial visit occurs within seventy-two (72) hours of discharge;
    - The Covered Person is confined to a home;
    - The care needed includes intermittent skilled nursing care or physical therapy in conjunction with skilled nursing care;
    - The skilled nursing services are provided only by a Registered Graduate Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.); or in the case of physical therapy, by a Registered Physical Therapist (R.P.T.); and
    - The care provided is Medically Necessary and requires the technical proficiency and skills of an R.N. or L.P.N.

The Medical Necessity of the initiation and continuation of home health care will be reviewed. If services are determined not to be Medically Necessary, benefits will be denied. Whenever the level of care falls below that requiring the skills of an R.N., L.P.N. or an R.P.T., as the case may be, benefits will be discontinued.

16. **Hospice Care:** Hospice care on either an inpatient or outpatient basis as an alternative to hospitalization for a terminally ill person, to the maximum specified in the **Schedule of Medical Benefits**.

Covered services must be rendered, furnished and billed by a Hospice and included in a written Hospice treatment plan established and periodically reviewed by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). The Hospice treatment plan must:

- Certify that the person is terminally ill;
- Certify that it is not medically advisable for the person to leave home;
- Certify that Hospital confinement would be required in the absence of Hospice care;
- Describe the services and supplies for the palliative care and Medically Necessary treatment to be provided to the Covered Person by the Hospice.

Covered services include:
Room and board, services and supplies furnished by a Hospice while confined therein;

- Patient care provided by home health aides;
- Visits by medical social workers;
- Visits by physical and psychotherapists;
- Nutritional counseling;
- Intermittent care by a Registered Graduate Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);
- Drugs and medicines for the terminal illness that are legally obtainable only upon a Physician's written prescription and insulin;
- Medical supplies normally used for Hospital inpatients, such as oxygen, catheters, needles, syringes, dressings, materials used in aseptic techniques, irrigation solutions, intravenous solutions and other medical supplies including splints, trusses, braces or crutches;
- Rental of Durable Medical Equipment such as wheelchairs, Hospital beds, or respirators.

In addition to the **General Limitations** in this Plan, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services except by home health aides as ordered in the Hospice treatment plan;
- Supportive environmental materials such as handrails, ramps, air conditioners and telephones;
- Services performed by family members or volunteer workers;
- "Meals on Wheels" or similar food services;
- Separate charges for records, reports or transportation;
- Expenses for the normal necessities of living, such as food, clothing and household supplies;
- Any services or supplies not included in the Hospice treatment plan or not specifically set forth as a covered service;
- Bereavement, pastoral or spiritual counseling;
- Legal and financial counseling services;
- Services provided during any period of time in which the Covered Person is receiving benefits under this Plan's Home Health Care Benefit.

17. **Hospital Services:**

Inpatient

- Hospital room and board, general nursing care, and regular daily services to the room and board allowance shown in the **Schedule of Medical Benefits.**
- Intensive Care Unit or other special care unit such as Coronary Care, up to the amount specified in the **Schedule of Medical Benefits** (but not for the concurrent use of any other Hospital room).

The following are Hospital Services, when performed on an inpatient or outpatient basis:

- Operating room and recovery room use, including outpatient surgery;
- Drugs and medicine for use in the Hospital, as needed, and listed in the "New and Non-Official Remedies" and the "United States Pharmacopoeia";
- Solutions, including glucose;
- Dressings, including ordinary casts;
- Anesthesia, when administered by a regular salaried employee of the Hospital;
- Anesthesia supplies and equipment;
- Respiratory therapy;
- Transfusion supplies and equipment;
- Diagnostic x-ray and laboratory/pathology services;
- Electrocardiograms, electroencephalograms, and other approved machine testing;
- Physical therapy and its modalities, excluding biofeedback;
- Radiation therapy services;
- Other Medically Necessary Hospital services and supplies.

18. **Lenses After Cataract Surgery:** Initial purchase of cataract lenses, or follow-up when a prescription change is Medically Necessary.

19. **Massage Therapy:** Massage Therapy rendered by a Physician or qualified physical therapist. Massage therapy visits are limited to a maximum of 30 visits per year. Massage Therapy will only be covered at the SMH HealthFit facility located at 5880 Rand Boulevard, or at the main SMH campus in Sarasota, FL, up to 30 visits per plan year with a doctor's prescription. The Basic plan also requires Medical Management approval before medical massage therapy is covered. OOA Students and Extended Plan members have open access outside of the Sarasota Area for massage therapy, but massage therapy rendered in the Sarasota area will only be allowed at SMH/HealthFit.

20. **Maternity Expenses:** Expenses incurred by a Covered Employee and Covered Dependent , including charges for confinement in a Birthing Center and the services of a certified Nurse Midwife for:

- Pregnancy;
- Complications of Pregnancy (see the Definitions section);
- Elective induced abortions only when carrying the fetus to full term would seriously endanger the life of the mother or in the event of incest or rape;
- If complications arise after the performance of an abortion, any eligible expenses incurred to treat those complications will be considered, but the initial cost relating to the abortion, except those specified above, will not be considered;
- Benefits for any hospital stay in connection with childbirth, for the mother or the newborn child, will not be restricted to less than 48 hours following a normal vaginal birth or 96 hours following a cesarean section. The attending Physician may, however, discharge the mother and/or baby earlier than the normally required 48 or 96 hours *after consulting with the mother*.

The following notice is provided in compliance with the Newborns' and Mothers' Health Protection Act of 1996:

> Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Physician (e.g., your Physician, nurse, or midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.
>
> In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

21. **Medical-Surgical Supplies:** Medically Necessary services and supplies including ostomy supplies.

22. **Mental/Nervous Conditions:**

Inpatient

Hospital and professional services during the course of a confinement, provided services are rendered by a licensed Physician, Licensed Psychologist, or a Licensed Mental Health Professional;

Outpatient

Outpatient care and treatment, provided services are rendered by a licensed Physician, Licensed Psychologist, or a Licensed Mental Health Professional.

In-Home Mental Health Services

Services provided in the home or school setting by an in-network Board Certified Behavioral Analyst (BCBA) will be allowed. Other in-network mental health providers will be allowed to provide these types of services on a case by case basis as authorized by EAP.

All non-emergency behavioral health care must be pre-certified by EAP.

23. **Newborn Expenses:**

Newborn expenses for the following:

- Hospital nursery expenses;
- Routine pediatric care for a healthy newborn child while confined in the Hospital immediately following birth;
- Circumcision.

If the baby is ill, suffers an Injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expense provided coverage is in effect.

24. **Orthotic Devices:** An orthotic device is any rigid or semi-rigid device used for the purpose of supporting a weak or deformed body member, or restricting or eliminating motion in a diseased or injured part of the body for conditions arising out of an illness or Injury. This does not include arch

supports, orthopedic shoes, or shoe inserts. See your specific Plan exclusions for orthotic devices. The Basic Plan does not have coverage for Orthotic Devices.

25. **Oxygen:** Oxygen and rental of equipment for its administration.

26. **Physical Therapy:** Physical Therapy rendered by a Physician or qualified physical therapist. Physical therapy is the treatment of an illness or Injury by physical or mechanical means such as traction, active or passive exercises, or heat treatment. Physical Therapy, Occupational Therapy, and Speech Therapy visits are limited to a combined maximum of 30 visits per year except in the case of post joint replacement therapy with pre-authorization from Case Management.

27. **Physicians' Services:** Physicians' fees for medical and surgical services in the office, and inpatient and outpatient departments of a Hospital; services of an assistant surgeon when required, but not to exceed 20% of the primary surgeon's allowable amount.

    When multiple surgical procedures are performed, benefits are restricted as follows:
    - When more than one related procedure is done through the same incision, benefits will be limited to the maximum allowable amount for the primary procedure;
    - When multiple procedures are performed on different body parts at the same time, the primary surgery will be provided to the full allowance and the additional procedures will be allowed either 25% or 50% of the allowance, depending on the number and nature of the procedures.

28. **Prescriptions:** Benefits will be provided for drugs and medicine which require a written prescription by a Physician and are dispensed by a licensed pharmacist, and are listed in the "New and Non-Official Remedies" and the "United States Pharmacopoeia."

29. **Preventive and Wellness Services:** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the **Schedule of Medical Benefits**. Certain additional preventive care services will be covered without your having to pay a copayment or co-insurance or meet your deductible, as long as the services are provided by a network provider, and are in accordance the US Preventive Services Task Force Recommendations. A current listing of Preventive Care services provided at no cost to you can be accessed at https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1.

30. **Private Duty Nursing Services:** Private duty nursing services are those which are furnished by or under the direct supervision of professionally trained and licensed nursing personnel (under the general direction of a Physician) to achieve the medically desired result and to assure safety.

    Private duty nursing service may be:
    - The rendering of direct service, when the ability to provide the service requires specialized (professional) training;
    - Observation and assessment of medical needs;
    - Supervision of a medical treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired medical results.

    A plan of treatment which does not require such skilled nursing services and is designed solely to assist the Covered Person with the activities of daily living or to provide the protection of an institutional environment as a convenience to the Covered Person or their family are not covered.

    Private duty nursing will not be covered on an inpatient basis unless:
    - No intensive care unit (ICU), cardiac care unit (CCU), or surgical intensive care unit (SICU) is available;

- Constant skilled nursing care is ordered by the attending Physician and is Medically Necessary; and
- The care provided requires the technical proficiency and skills of a Registered Graduate Nurse (R.N.) or Licensed Practical Nurse (L.P.N.).

NOTE: Benefits will be discontinued whenever the level of care falls below that requiring the skills of an R.N. or L.P.N., as the case may be.

31. **Prosthetics:** Purchase, fitting, necessary adjustments, repairs and replacement of prosthetic devices (not including dental appliances) which replace all or part of the function of a permanently inoperative or malfunctioning body organ, as shown in the **Schedule of Medical Benefits**.

32. **Radiation Therapy and Chemotherapy:** X-ray, radium, radioactive isotope therapy, and chemotherapy when rendered by a Physician.

33. **Rehabilitation Services:** Rehabilitation services following an Injury or a debilitating illness, such as a heart attack or a cardiovascular accident, to the limits specified in the **Schedule of Medical Benefits**. Covered services include occupational, speech, massage, and respiratory therapy.

34. **Routine Mammograms:** Routine mammograms for covered females age thirty-five (35) and over as specified in the **Schedule of Medical Benefits**.

35. **Skilled Nursing Facility**: Confinement in a Skilled Nursing Facility, to the limits specified in the Schedule of Medical Benefits, provided:
    - Such confinement begins within 14 days after an eligible Hospital confinement of at least three (3) days duration, not including the day of discharge;
    - Such confinement is under the supervision of a Physician; and
    - The attending Physician certifies twenty-four (24) hour nursing care is necessary for recuperation from the Injury or illness which required Hospital confinement; and care is actually received on a daily basis.

    Covered services in a Skilled Nursing Facility do not include the type of care that is considered Custodial, such as in a rest home, or a home for the aged, or the treatment of Mental and Nervous Conditions, Chemical Dependency, or Alcoholism. The Medical Necessity of a Skilled Nursing Facility admission and continued stay will be reviewed. If services are determined not to be Medically Necessary, benefits will not be covered.

    Covered services include:
    - Daily room and board;
    - Drugs and medicine for use in the Hospital, as needed, and listed in the "New and Non-Official Remedies" and the "United States Pharmacopoeia;"
    - Solutions, including glucose;
    - Dressings, including ordinary casts;
    - Respiratory therapy;
    - Transfusion supplies and equipment, excluding whole blood or blood plasma;
    - Diagnostic x-ray and laboratory/pathology services;
    - Electrocardiograms, electroencephalograms, and other approved machine testing;
    - Physical therapy and its modalities, excluding biofeedback;
    - Other Medically Necessary Hospital services and supplies.

36. **Sterilization:** Voluntary sterilization, including vasectomy and tubal ligation.

37. **Transplants**: Transplantation of a covered tissue and organ transplant, as defined below, if employee is working with Chronic Disease Case Management, approved by Medical Management, and if performed at a facility approved by Medical Management subject to those conditions and limitations described below.
Transplantation includes pre-transplant, transplant, and post transplant services, and treatment of complications after transplantation. We will pay benefits only for services, care and treatment received for or in connection with the approved transplantation of the following human tissues or organs;
- Heart
- Lung
- Liver
- Kidney
- Heart/Lung
- Pancreas
- Bone marrow, as defined herein, which is specifically listed in Chapter 10D-127.001 of the Florida Administrative Code.

As used in this Plan, the term "bone marrow transplant" means human blood precursor cells that are administered to a patient to restore hematological and immunological functions following ablative therapy with curative intent. Such cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, circulating blood, or combination. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes both the transplantation and the chemotherapy.

38. **Vision and Hearing Screening:** Included under Well Child Care, as shown in the **Schedule of Medical Benefits**. Diagnostic Audiograms are covered for children when performed at All Children's Hospital or ENT MD offices that are pre-approved by Medical Management (applicable deductibles, co-pays, and co-insurance apply).

39. **Voluntary Second Surgical Opinion:** When elective, non-emergency surgery is recommended for a Covered Person, benefits will be paid, at a reduced rate as shown in the **Schedule of Medical Benefits,** for expenses associated with getting a second opinion before the surgery is performed. Benefits for the second opinion will be payable only if the opinion is given by a specialist who:
- Is certified or is eligible to be certified in a field related to the proposed surgery; and
- Does not perform the surgery for the Covered Person.

40. **Wigs:** Covered up to $300 after chemotherapy. See **Comprehensive and Extended Medical Plan Exclusions** for exclusions to coverage.

Disease Management Programs

Pharmacy Insulin Program – PIP

Pharmacy Case Management has added a new benefit called Pharmacy Insulin Program (PIP). PIP is for Insulin dependent members with Type 1 or Type 2 diabetes. PIP prevents members from exceeding their pharmacy benefit cap because of the increased insulin cost. PIP provides additional support for Rx Extended Plan members.

PIP increased support for members:

- Pharmacy Case Management Support
- Insulin cost will not apply towards pharmacy cap
    - $100 Co-pay only for Novixus at mail order
- Physician guidance
- SMH Diabetes Education
- Nutritional counseling
- Chronic Disease Management

Criteria for Program:

- Enrolled in Rx Extended Plan
- Meet with Pharmacy Case Manager
- Meet with Chronic Disease Manager
- Denial letter from Patient Assistance Program

For more information visit www.gulfcoastmemberservices.org or call 941-917-1473.

Diabetes Treatment Program

Designed to improve the quality of life and medical outcomes for Members diagnosed with diabetes, this Program promotes nationally recognized guidelines for the treatment of diabetes. It does so by providing ongoing assessment, monitoring, feedback and education tools for Members with diabetes and their families through specially trained registered nurses and registered dieticians in coordination with the Member's Physician.

Members who have a diagnosis of diabetes will be enrolled in the Program, offered through Sarasota Memorial Hospital Diabetes Treatment Services, by a referral from their Physician. They will receive a risk assessment and be provided with a tailored education and monitoring Program. This Program includes all aspects of diabetes management, including diet, medication and exercise. This program is covered at 100% and is not subject to deductibles or co-insurance.

Anticoagulation Clinic

The Anticoagulation Clinic of Sarasota Memorial Hospital provides ongoing monitoring and care for people taking warfarin (Coumadin, Jantoven) and low molecular weight heparins, also called "blood thinners." These medications are prescribed to prevent the formation of harmful blood clots that could lead to deep vein thrombosis or stroke.

Small changes in medications, diet and exercise can dramatically affect your therapy, so careful monitoring is important to prevent complications of this therapy. Everyone responds differently to warfarin; as such, frequent visits may initially be needed to determine your stable dosage. Once your dosage is stabilized, an appointment will be made about every four weeks for management and follow-up.

Our clinic staff includes a Physician medical director, nurse practitioner specialist, and highly trained nursing staff who provide assessment, education, management of your anticoagulation and coordination with your Physician.

The Heart Failure Center

The Heart Failure Center at Sarasota Memorial Hospital is designed to provide patients and families with comprehensive education and monitoring aimed at improving the ability to manage heart failure symptoms and improve quality of life. Our team's multidisciplinary patient care approach is a major emphasis of the Heart Failure Center. A Physician medical director and advanced registered nurse practitioner work together to serve the needs of the patients. Other specialists available as needed for the patients include clinical dietitian, registered pharmacist and clinical psychologist.

The outpatient Heart Failure Center offers a comprehensive assessment of heart failure etiology and risk assessment. Detailed services include:

- Diagnostic clinical evaluation
- Functional status assessment
- Dietary risk assessment
- Social risk assessment
- Patient and family education
- Physical activity evaluation

We work with each patient to create an individualized plan of outpatient clinic visits, frequent symptom and weight tracking by phone, expert pharmacological regimes, activity/rest and dietary guidelines, and ongoing communication with each patient's primary care Physician.

Chronic Disease Case Management

Chronic Disease Case Management is a free program offered to Participants with chronic diseases. Case managers can help a Participant get the care needed and can teach about the disease, help make a treatment plan, arrange doctor visits and help with referrals, and assist with getting treatments. With active participation in the Chronic Disease Case Management program, you may be eligible for a reduction in your Specialist office visit co-pay. For more information visit www.gulfcoastmemberservices.org or call 941-917-2956.

Nutrition Counseling

Visits with a Registered Dietitian will be covered when referred by Chronic Disease Case Management to the SMHCS Nutrition Counseling Program. The Member must pay a co-payment of $20.00 for each visit. To Schedule a Visit: 941-917-7468.

Extreme Obesity Intervention Program

The Extreme Obesity Intervention Program is a required program for Members who are considering Bariatric Surgery. This program will provide those who qualify with opportunities to prepare for, and work towards, their expected outcomes. The Member will receive wellness coaching, nutritional counseling support, and a personal trainer, with the goal of showing success in weight loss and improvement of overall fitness. The member will have a referral to EAP for an opportunity to gain additional wellness learning knowledge and behavior modification. The Extreme Obesity Intervention Program may delay or defer surgery, or increase the chance of success post- operatively. To qualify, the Member must be enrolled in the Chronic Disease Case Management program, receive pre-authorization from the Chronic Disease Case manager and the Medical Directors, and pay applicable program co-pays. For more information or to apply for the program, enroll in the Chronic Disease Case Management program at www.gulfcoastmemberservices.org and request more information.

Certificates of Creditable Coverage

The Plan will issue a Certificate of Creditable Coverage, automatically and without charge, under the following circumstances:

- For an individual who is a Qualified Beneficiary entitled to elect COBRA coverage, the Certificate of Creditable Coverage will be issued with the COBRA notice sent after the Qualifying Event.
- For an individual who loses coverage under the Plan, but is not entitled to COBRA coverage, the Certificate will be issued as soon as reasonably possible after coverage ends.
- For an individual who is a Qualified Beneficiary and has elected COBRA coverage, the Certificate will be issued within a reasonable time after COBRA coverage ends or, if applicable, after the expiration of any grace period for the payment of COBRA premiums.

The Plan will also issue a Certificate of Creditable Coverage at any time within 24 months after coverage ends, provided that the Plan receives a written request for the Certificate by the former Plan Participant (or by another person authorized by the former Plan Participant). Certificates of Creditable Coverage will be in the form required by HIPAA. This Plan will assist individuals in obtaining Certificates from prior health plans.

MEDICAL PLAN DEFINITIONS

Accident Or Accidental Injury: A specific unforeseen sudden event occurring by change and resulting in bodily Injury sustained independently of all other causes.

Billed Charges: The amount that a Participating Provider routinely charges for the provision of Health Care Services.

Calendar Year: The twelve (12) month period of January 1 through December 31 inclusive.

Change In Family Status: Change in Family Status means:

- Marriage, divorce or retirement;
- Birth or adoption of a child;
- Change in a spouse's employment status (such as losing a job or becoming employed);
- A change in the work status of you or your spouse (ie, full-time to part-time or the reverse);
- Unpaid leave of absence;
- Death of the spouse or child;
- Dependent no longer eligible (such as exceeding the age of eligibility or no longer meeting student status);
- Entitlement to or loss of Medicare or Medicaid Coverage;
- Entry of a qualified medical child support order requiring you to provide medical benefits to a Dependent.

Chemical Dependency/Alcoholism:

Chemical Dependency: A condition in which a person is dependent upon, or by reason of repeated use, is in imminent danger of becoming dependent upon any substance.

Alcoholism: A condition in which a person chronically and habitually uses alcoholic beverages to the extent that it Injures the person's health or substantially interferes with social or economic functioning; or to the extent that such person has lost the power of self-control with respect to use of alcohol.

Claim Administrator: See Third Party Administrator

Co-Insurance: The percentage amount that a Covered Person is required to make for Covered Services and in instances where a co-payment is required, after the co-payment has been paid.

Complications Of Pregnancy: Conditions with a diagnosis distinct from pregnancy but which may be caused by or adversely affected by pregnancy. Complications include but are not limited to:

- Nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; and
- Cesarean section, termination of ectopic pregnancy and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

"Complications of Pregnancy" shall not include false labor, morning sickness, occasional spotting, Physician-prescribed bed rest during the period of pregnancy, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy but not constituting a nosologically distinct Complication of Pregnancy.

Contribution: The cost, if any, contributed by the Employee for elected coverage under this Plan, as determined by the Employer, and which may be changed from time to time.

Co-Payment: The fixed-dollar amount that a Covered Person must pay for Covered Services before benefits are payable by plan. For Members in the Basic and Comprehensive Plans, co-payments do not count toward a Covered Person's Deductible or Out of Pocket Maximum.

Cosmetic Procedure: A procedure performed primarily for the improvement of a covered person's appearance rather than for the improvement or restoration of bodily function.

Covered Dependent: Any eligible Dependent whose coverage has become effective and has not terminated.

Covered Employee: Any eligible employee whose coverage has become effective and has not terminated.

Covered Person: Any eligible Employee, eligible Retiree or eligible Dependent whose coverage has become effective and has not terminated.

Covered Retiree: An eligible Retiree whose coverage has become effective and has not terminated.

Custodial Care: Any room and board, nursing services, and other institutional services that are primarily for daily living maintenance, even though the person is receiving medical services, when these services cannot reasonably be expected to substantially improve a medical condition. Custodial Care is not covered under this Plan.

Deductible: The fixed-dollar amount that a Covered Person must pay for Covered services before benefits are payable by plan.

Default Plan: Coverage for benefit-eligible Employees who do not enroll will default to no medical plan coverage.

Dependent: An individual who satisfies **all** of the requirements listed under "Eligibility Requirements – Dependents" and who has enrolled in the Plan.

Durable Medical Equipment: Equipment prescribed by the attending Physician which meets all of the following requirements:

- It is Medically Necessary;
- It is primarily and customarily used to serve a medical purpose;
- It is designed for prolonged and repeated use;
- It is not useful to the person in the absence of illness or Injury;
- It does not serve as a comfort or convenience item.

Effective Date of Coverage: The date the Participant becomes eligible for coverage under the Plan which is the 61st day of regular full-time or part-time employment.

Eligible Charges: The amount of Billed Charges the plan will pay to provider for Covered Services under a Service Agreement.

Eligible Employees: Employees who are classified as regular employees working at least 20 hours per week or 40 hours a pay period, or a temporary or Per Diem employee who has averaged 30 or more hours per week over the last year of employment.

Emergency: An emergency means a condition for which Emergency Services are required.

Emergency Room Services: Those services necessary to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part; or such other definition as may be required by applicable law.

Employee: A person whom the Employer considers a common law employee for payroll purposes who is directly employed by the Employer for pay in the conduct of the Employer's regular business.

Employer: Means SMHCS or any other entity, firm or corporation, which may succeed to the business of, SMHCS by merger, consolidation or otherwise.

Essential Health Benefits: A set of health care service categories that must be covered per the Affordable Care Act. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental or Investigational: means, a treatment, device, or drug other than covered off-label drug use that:

A) Is governed by the United States Food and Drug Administration ("FDA") and the FDA has not approved the treatment, device or drug for the particular condition at the time the treatment, device or drug is provided; or

B) Is provided as part of an ongoing Phase I or II clinical trial as defined by the National Institutes of Health, National Cancer Institute or the FDA. In the event that an FDA approved drug or device is used for a particular condition during an ongoing Phase I or II clinical trial, and one or more other drugs or devices not FDA approved for such trial are also used, then all FDA approved and FDA non-approved drugs or devices shall be considered experimental or investigational; or

C) Is documented in published U.S. peer-reviewed medical literature stating that further research, studies, or clinical trials are necessary to determine the safety, toxicity or efficacy of the treatment, device or drug; or

Is any treatment, device, drug or hospital confinement that arises from, relates to, or is provided in connection with the Experimental or Investigational treatment or drug whether or not the treatment, drug or hospital confinement, on their own, are considered standard of care or Medically Necessary.

Facility: Facility includes Hospitals, Emergency care centers, surgery centers, psychiatric Hospitals, home health care agencies, nursing homes, rehab centers, and urgent care centers.

Family and Medical Leave Act of 1993 (FMLA): A leave of absence granted to an eligible employee by the Employer in accordance with Public Law 103-3 for the birth or adoption of the employee's child, the Serious Health Condition of the employee's spouse, child or parent, and the employee's own disabling Serious Health Condition.

Fee Schedule: A Schedule of Fees negotiated by Physicians, hospitals, and the provider networks to provide the most cost effective health care services.

Fiduciary: The person or organization that has the authority to control and manage the operation and administration of the Plan. The Fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of this Plan. The Named Fiduciary for this Plan is the Employer.

Four Tier Plan:
- Employee
- Employee plus Spouse
- Employee plus Child(ren)
- Employee plus Family (Includes spouse and child(ren))

Full-Time Student: A Participant's Dependent Child who is a student at an accredited institution of higher learning who is enrolled for at least 12 credit hours per school term, or who otherwise meets the definition of "full-time" student as established by the institution the student is attending.

Genetic Information: Information about the genes, gene products and inherited characteristics. This information may be obtained from lab tests to identify genetic mutations, physical examinations, family histories and direct genetic analysis.

Home Health Care Agency: A Hospital or a public or private home health care service or agency which is either free-standing or part of an acute care general Hospital which provides skilled nursing and various therapeutic services to persons who are homebound, and serves in lieu of continued Hospital care. The organization must be licensed by the state of Florida as a Home Health Care Agency.

Hospice: A facility or health care program providing services to the terminally ill and their families, that meets Medicare qualification criteria, or meets all state regulations.

Hospice Care: A program of care which provides pain free and alert existence for the terminally ill patient during the last months of life, while actively including the family in the care. It can accomplish this by either inpatient care or home care but emphasizes home care.

Hospital: A Facility, or a distinct part of one which:
- is licensed as a Hospital in the jurisdiction it is in;
- charges for the services and supplies it provides;
- keeps a medical record of each patient;
- provides an ongoing quality assurance program with reviews by MDs or DOs;
- primarily provides inpatient services on the premises for surgical and medical diagnosis,
- treatment or care of diseased or injured persons;
- is supervised 24 hours a day by staff of MDs or DOs;
- provides 24-hour-a-day skilled nursing services by RNs;
- is accredited by the Joint Commission or Det Norske Veritas (DNV).

Even though it provides medical or psychiatric treatment, it is not primarily:
- a nursing home;
- a convalescent or extended care Facility;
- a place of rest for the aged;
- a place for drug addicts or alcoholics;
- a place providing education or behavior modification services in a residential setting or for children or adolescents with behavioral social problems, mental retardation or autism;
- a Hospital is not a place for career advice, job training, vocational rehabilitation and/or a place to reside, play or exercise.

Illness: The term "Illness" shall include disease, mental, emotional, or nervous disorders, and pregnancy.

Injury: The term "Injury" shall mean only accidental bodily Injury. All Injuries sustained by a Covered Person in connection with any one accident shall be considered one Injury.

Licensed Mental Health Professional: An individual who is licensed to aid in the treatment of Mental and Nervous Conditions. This professional may be a psychiatric social worker, mental health technician, or psychiatric nurse. (Where there are no licensure laws, the mental health professional must be certified by the appropriate professional body in order to render treatment of mental and nervous disorders).

Licensed Psychologist: An individual who is legally qualified to diagnose and provide professional treatment of Mental and Nervous Conditions which may include diagnosis and assessment of mental disorders, cognitive impairment, and social adjustment. (Where there are no licensure laws, the Psychologist must be certified by the appropriate professional body in order to render psychological tests).

Maternity: Maternity benefits are provided to the female Employee and the spouse of the male Employee, as well as eligible dependent children of the Employee, subject to the same limitations and exclusions as all other conditions under the Plan. Recognized providers of Maternity services are Physicians (MD) and osteopaths (DO). The newborn child is covered for a maximum of 30 days, unless added to the plan as an eligible dependent.

Medically Necessary/Medical Necessity: Medically Necessary shall mean that the services or supplies provided to a patient by a hospital, skilled nursing facility, Physician or other licensed medical provider are required to identify or treat an illness, pregnancy or Injury which a Physician has diagnosed or reasonably suspects, or to provide well baby or child care or preventive services. To be Medically Necessary, the services must:

- be consistent with the diagnosis and treatment of the patient's condition based on recognized standards of the health care specialty involved or as set forth in guidelines issued by the American Medical Association;
- be in accordance with standards of good medical practice as effective, safe, and essential;
- not be solely for the convenience of the patient, Physician, or supplier; and
- be performed in the most appropriate setting required by the patient's medical condition.

Just because a service is recommended by a Physician does not mean the service is Medically Necessary. In an effort to make treatment convenient, to follow the wishes of the patient or the patient's family, to investigate the use of unproven treatment methods, or to comply with local hospital practices, a Physician may suggest or permit a method of providing care that is not Medically Necessary. A determination that a service or supply is not Medically Necessary may apply to the entire service or supply or to any part of the service or supply. Medical Necessity shall have the same meaning as Medically Necessary.

Medical Expense: Medical Expense means the Fee Schedule charges or the usual, customary and reasonable or the UCR charges incurred by the Participant as the result of an Injury or Illness for Medically Necessary services, treatments, supplies, or drugs. Medical Expense will be considered to be incurred as of the date of the performance of the service or treatment, or the date of purchase of the supply or drug.

Medicare: Part A and Part B of the insurance program established by Title XVIII, United States Social Security Act, as amended, 42 U.S.C. Sections 1394, et seq.

Member: An Employee, Retiree or Dependent who is enrolled in the Plan and satisfies the eligibility and participation requirements specified in this Summary Plan Description.

Mental/Nervous Condition: Means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions and psychiatric conditions. This includes but is not limited to the following conditions: psychoses, schizophrenic disorders, mood and affective disorders, personality disorders and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

Network: The contracted panel of providers who deliver medical services to the Plan Members.

Network Provider: Providers of services who are included in the Gulf Coast Select Network, Gulf Coast Provider Network and the First Health Network. Members on the Basic and Comprehensive Plan must utilize the Gulf Coast Select Network. Members on the Extended Plan and residing in the two county area of Sarasota and Manatee Counties are to use the Gulf Coast Provider Network. Members residing or traveling outside of those areas are to access the First Health Network. Network information is also available online at http://www.gulfcoastprovider.net or by calling 941-917-4004 or toll free 866-917-4004.

Medical Management: Services reviewed by a professional health care management company to ensure cost-effective quality of care and to assist in determining whether or not proposed services are appropriate for reimbursement under the Plan.

Non-Occupational: The terms Non-Occupational disease and Non-Occupational Injury mean a disease or Injury which does not arise, and which is not caused or contributed to, by, or as a consequence of, any disease or Injury which arises out of, or in the course of, any employment or occupation for compensation or profit.

Open Enrollment: Open Enrollment means the period, determined by SMHCS, in which Participants may enroll, elect or change benefit coverage.

Out-of-Area Child: A Dependent child residing outside of the Gulf Coast Provider Network Select service area.

Out-of-Network Provider: Providers of services who are not included in the Gulf Coast Provider Network Select (for Comprehensive and Basic plans); or Gulf Coast Provider Network and First Health Network Directory (for Out-of-Area Children and Extended plan).

Out-of-Pocket: The limit of each Covered Persons share of Co-Insurance during a Plan Year. For Members in the Basic and Comprehensive Plans, Co-payments and Deductibles do not count toward a Covered Persons Maximum Medical Out-of-Pocket.

Participant: An Employee, Retiree or Dependent who is enrolled in the Plan and satisfies the eligibility and participation requirements specified in this Summary Plan Description.

Physical Disability: Physical Disability means a physical condition which causes a person to be incapable of performing the usual and customary duties or activities of an individual of the same age and sex who is in good health, and substantially incapable of self-sufficiency.

Physician: A Physician shall be a properly licensed person holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), or Licensed Clinical Psychologist.

Physician shall also include other licensed practitioners of the healing arts if a Covered Person is referred by one of the above listed individuals acting within the scope of their license.

The Physician may not be an immediate relative of, or member of, the Participant's household.

Plan: The plan of benefits as contained in the Summary Plan Description and any agreements, schedules and amendments endorsed by the Employer.

Plan Document: This booklet which is the Plan document for the SMHCS Health and Wellness Plan. This booklet also serves as the Summary Plan Description for the SMHCS Health and Wellness Plan and the SMH Health Care, Inc. Flexible Benefits Plan.

Plan Sponsor: The legal entity that is responsible for the Plan design and contents and is obligated to pay all benefits as outlined in the Summary Plan Description. In this case, SMHCS is the *Plan Sponsor*.

Plan Year: Plan Year means the 12-month period beginning on October 1 and ending on September 30 each year. All annual benefit maximums and Deductibles accumulate during and are calculated based on the Plan Year. For purposes of the flexible spending accounts, the Plan Year is the 12-month period beginning on January 1 and ending on December 31.

Pre-Authorization: Obtaining approval from Medical Management (MM) prior to any non-emergency Hospital admission, inpatient surgery and certain outpatient services, per the "Pre-Authorization Requirements" section of this document.. If the admission is due to an Emergency, notification must be made within 48 hours (72 hours on weekends and holidays). Failure to obtain a timely pre-certification from MM will result in services being paid at 50%. The Pre-authorization telephone number is located on the Plan ID card.

Pre-Tax: The amount of Contribution an Employee makes to this Plan that is not subject to Social Security and Federal Income Taxation.

Preferred Provider: Any Hospital, facility, Physician, or other provider who has contracted with the Gulf Coast Provider Network to provide health care services at a negotiated rate.

Preventive Services/Care: Evidence-based items and services as required by applicable law if provided by a Network Provider, and are in accordance with US Preventive Services Task Force Recommendations, certain immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and certain preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration. A current listing of required preventive care can be accessed at https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1.

Re-admission: An admission or admissions of a Covered Person as an inpatient in a Hospital or Hospitals for treatment. Re-admission to a Hospital within thirty (30) days of discharge from a Hospital or Skilled Nursing Facility for the same or related condition shall be determined to be continuous and constitute a single confinement.

Registered Graduate Nurse (R.N.) or Licensed Practical Nurse (L.P.N.): A person duly licensed by the state in which the person is engaged in the practice of nursing as a Registered Graduate Nurse (R.N.) or Licensed Practical Nurse (L.P.N.).

Registered Physical Therapist: A person who is duly registered by the state in which the person is engaged in physical therapy practice and who is a member of the American Physical Therapist Association or American Registry of Physical Therapists.

Retiree: A terminated Employee who satisfies the eligibility requirements for retiree medical benefits.

Serious Health Condition: An illness, Injury, impairment or physical or mental condition that involves inpatient care in a Hospital, Hospice, or residential medical care facility; or continuing treatment by a health care provider as defined in Public Law 103-3.

Skilled Nursing Facility: An institution which is primarily engaged in providing inpatient skilled nursing care and twenty-four (24) hour nursing service sufficient to meet the nursing needs of those individuals not requiring an acute level of skilled nursing care in an acute care general Hospital. The facility can be either a free-standing institution or a part of a Hospital.

Summary Plan Description (SPD): This booklet which summarizes the Plan provisions of the SMHCS Health and Wellness Plan and the SMH Health Care, Inc. Flexible Benefits Plan. The booklet serves as both the SPD and the Plan Document for the Health and Wellness Plan and as the SPD for the Flexible Benefits Plan.

Termination of Coverage: Coverage will be terminated (subject to COBRA) the end of the pay period in which the last day of employment falls.

Third Party Administrator: The person/organization providing consulting services to the Employer in connection with the operation of the medical Plan and performing such other functions, including processing and payment of claims as may be delegated to it. The Third Party Administrator is:

WEBTPA
PO Box 99906
Grapevine, TX 76099-9706

Transplant: A human-to-human transplant of a liver, heart, lung, kidney, pancreas, and autologous or allogenic bone marrow.

Transplant Covered Expenses: The expenses incurred related to a Transplant including, but not limited to supplies, drugs, procurement, and transportation which are Medically Necessary and appropriate to the Transplant.

Usual and Customary Charges (also known as Reasonable and Customary Charges): The most frequent charges which an individual Physician charges to the majority of patients for a given procedure. These charges must be within the range of fees charged by most Physicians of similar training and experienced in a given geographical area for this same procedure, with consideration given to unusual circumstances involving medical complications requiring additional time, skill and experience.

Waiting Period: Means the period of time between the first day of employment as a regular employee and the first day of coverage under the Plan.

Transplant Schedule of Benefits

TRANSPLANT PROCEDURE	*TRANSPLANT NETWORK IN-NETWORK BENEFITS*	*NON-NETWORK TRANSPLANT NETWORK NON-NETWORK BENEFITS*
HEART	100% of Eligible Charges	90% of eligible charges, up to an overall maximum of *$110,000* including organ acquisition and a Physician's maximum of *$20,000*.
LUNG	100% of Eligible Charges	90% of eligible charges, up to an overall maximum of *$155,000* including organ acquisition and a Physician's maximum of *$20,000*.
BONE MARROW	100% of Eligible Charges	90% of eligible charges, up to an overall maximum of *$130,000* including marrow acquisition and a Physician's maximum of *$20,000*.
LIVER	100% of Eligible Charges	90% of eligible charges, up to an overall maximum of *$130,000* including organ acquisition and a Physician's maximum of $20,000.
HEART/LUNG	100% of Eligible Charges	90% of eligible charges, up to an overall maximum of *$150,000* including organ acquisition and a Physician's maximum of *$20,000*.
PANCREAS	100% of Eligible Charges	90% of eligible charges, up to an overall maximum of *$70,000* including organ acquisition and a Physician's maximum of *$20,000*.
KIDNEY	100% of Eligible Charges	90% of eligible charges, up to an overall maximum of *$55,000* including organ acquisition and a Physician's maximum of *$20,000*.

Pre-Authorization Requirement for Organ Transplant*

Covered expenses incurred in connection with any organ or tissue transplant listed in this provision will be covered subject to referral to and pre-authorization by the Plan Sponsor's authorized review specialist. Transplant coverage is offered under this plan through a preferred provider network of specialized professionals and facilities. Coverage is also provided for Transplant services obtained outside of the preferred network, at a reduced benefit level. Eligible Employees must be participating in the Chronic Disease Case Management program.

As soon as reasonably possible, but in no event more than ten (10) days after a Covered Person's attending Physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or his Physician should contact the Plan Sponsor for referral to the network's medical review specialist for evaluation and pre-authorization. A comprehensive treatment plan must be developed for this Plan's medical review, and must include such information as diagnosis, the nature of the transplant, the setting of the procedure, (i.e. name and address of the hospital), any secondary medical complications, a five year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment. (One or both confirming second opinions may be waived by the Plan's medical review specialist). Additional attending Physician's statements may also be required. The Covered Person may provide a

comprehensive treatment plan independent of the preferred provider network, but this will be subject to medical appropriateness review and may result in non-network benefit coverage.

All potential transplant cases will be assessed for their appropriateness for Large Case Management.

***Failure to pre-authorize a transplant procedure will result in the application of a $5,000 deductible to all covered expenses incurred as a result of the transplant. This deductible is in addition to any other Plan deductible and co-payment requirements, which would normally be applicable to the transplant procedure.**

Organ Transplant Network

As a result of the pre-authorization review, the Covered Person will be asked to consider obtaining transplant services at a participating transplant center. The term "participating transplant center" means "a licensed healthcare facility which has entered into a preferred provider agreement at fee arrangements to provide health services to the Gulf Coast Provider Network." The transplant network's goal is to perform necessary transplants in the most appropriate setting for the procedure with consideration of and enhancement of the quality of patient care.

There is no obligation for the patient to use network services. However, benefits for the transplant and its covered expenses may vary depending on whether services are provided in or out of the transplant network. If a transplant is performed out of network, but the Covered Person has received approval for the Plan's medical review specialist for out of network services, then network benefits will apply to the transplant and its covered expenses. If services are provided out of network without approval from the medical review specialist, then out of network benefits will apply.

Transplant Benefit Period

Covered transplant expenses will accumulate during a Transplant Benefit Period, and will be charged toward the transplant benefit period maximums, if any, shown in the Transplant Schedule of Benefits. The term "Transplant Benefit Period" means the period, which begins on the date of the initial evaluation and ends on the date, which is twelve consecutive months following the date of the transplant. (If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant).

Covered Transplant Expenses

Transplant Covered Services are the expenses incurred with respect to a Transplant, including, but not limited to, supplies, drugs, procurement, and transportation, which are Covered Services under this Plan (or which are specifically identified as Covered Services only under this provision) and which are Medically Necessary and appropriate to the Transplant.

1. Charges incurred in the evaluation, screening, and candidacy determination process.
2. Charges incurred for organ transplantation.
3. Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits.
   a) Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ.
   b) Charges for organ procurement for a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care.
   c) If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogeneic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of reinfusion. (The harvesting of the marrow need not be performed within the transplant benefit period).

4. Charges incurred for follow up care, including immuno-suppressant therapy.
5. Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two (2) other individuals. In addition, all reasonable and necessary lodging and meal expenses incurred during the transplant benefit period will be covered up to a maximum of $10,000 per transplant period.

Re-transplantation
Re-transplantation will be covered for up to two re-transplants, for a total of three transplants per person, per lifetime. Each transplant and re-transplant will have a new benefit period and a new maximum benefit.

Accumulation of Expenses
Expenses incurred during any one transplant period for the recipient and for the donor will accumulate towards the recipient's benefit.

Donor Expenses
Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a Participant under this Plan are limited to a maximum of $10,000 per transplant benefit period when the transplant services are provided out of network. This does not include the donor's transportation and lodging expenses.

Extended Benefits in the Event of Termination
In the event of termination of the Plan, or of the recipient's termination of membership in an eligible class, if a transplant treatment program had commenced while coverage was in force and benefits had not been exhausted, then benefits will be paid for expenses related to the same organ transplant which are incurred during the lesser of: a) the remainder of that transplant benefit period or, b) until the end of the first full calendar month following termination of the Plan or membership, as though coverage had not ended.

COMPREHENSIVE AND EXTENDED MEDICAL PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan Exclusions list.

For all Medical Benefits shown in the Schedule of Medical Benefits or Medical Plan Covered Services sections of the Summary Plan Description, a charge for the following is not covered:

1. **Abortion.** Charges for elective induced abortions, except for in the cases of rape, incest or maternal endangerment.

2. **Alcohol or Substance Impairment.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of alcohol or other substances causing impairment. Expenses will be covered for Injured Covered Persons other than the person using alcohol or substances causing impairment. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

3. **Biofeedback.**

4. **Breast or penile implants.** Coverage for breast or penile implants except for reconstructive surgery following mastectomy.

5. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

6. **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, tattoos or body piercings or removals of such items (including complications from either the applying or removing of such items), or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by Injury, disease, trauma, congenital/developmental anomalies, or previous covered therapeutic processes.

7. **Custodial care.** Services or supplies of a custodial care or domiciliary nature such as those normally provided at health resorts, rest homes, nursing homes, health spas, and convalescent centers. Also, services that are primarily educational in nature or any maintenance-type care which is not reasonably expected to improve the patient’s condition (except Hospice care as specified).

8. **Dental.** Services, supplies, care or treatment of dental or oral charges. Charges will be covered only to the extent specifically set forth in the Medical Plan Covered Services section of the Summary Plan Description and only within the Gulf Coast Provider Network. Dental extractions are not covered unless approved by the Medical Directors and member is active participant in Chronic Disease Case Management.

9. **Educational or vocational testing.** Services for educational or vocational testing or training.

10. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

11. **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for routine patient care of costs a Qualified Individual who is a participant in an approved clinical trial. Charges will be covered only to the extent specifically set forth in the Medical Plan Covered Services section of the Summary Plan Description and only within the Gulf Coast Provider Network.

12. **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

13. **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

14. **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

15. **Gene Therapy.** Care, treatment, or supplies for gene therapy or genetic testing and fetal treatment except to the extent specifically set forth in the Medical Plan Covered Services section of the Summary Plan Description or per Health Plan Medical Directors.

16. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

17. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy up to the limit shown in the Medical Plan Covered Services section of the Summary Plan Description.

18. **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of , but not limited to, hazardous hobbies or activities are skydiving, auto or motor cross racing, motorcycle riding without a helmet, boat racing, hang gliding, parasailing, or bungee jumping.

19. **Hearing related evaluations or treatments.** Charges for services or supplies in connection with hearing aids or exams for their fitting, including but not limited to, cochlear implants or any surgical procedure for hearing unless approved by Medical Directors and member is active participant in Chronic Disease Case Management.

20. **Hypnotherapy.** Charges for service or supplies in connection with hypnotherapy or hypnotism or any type of goal-oriented or behavior modification therapy, such as to quit smoking or lose weight.

21. **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of

this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

22. **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

23. **Infertility.** Charges or supplies for artificial insemination; in-vitro fertilization procedures or drugs, GIFT (Gamete IntraFallopian Transfer) procedures, studies, or drugs related to the treatment of infertility. Also excludes any charges relating to surrogacy, including, but not limited to, delivery charges.

24. **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

25. **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

26. **Emergency treatment for non-emergent conditions.** Emergency care and treatment billed by a Hospital or Facility for non-emergent conditions.

27. **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

28. **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

29. **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

30. **Obesity.** Screening and counseling for obesity will be covered to the extent required under Standard Preventive Care. Other care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness is excluded. Also excluded is removal of excess skin due to weight loss or excision of fat removal, unless pre-approved by Medical Directors.

31. **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

32. **Occupational Therapy.** Charges for occupational therapy, except as specified in the Medical Plan Covered Services section of the Summary Plan Description.

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

34. **Plan design exclusions.** Charges excluded by the Plan design as mentioned in this document.

35. **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

36. **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or the device is no longer functional.

37. **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Medical Benefits or required by applicable law.

38. **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

39. **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

40. **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

41. **Skin removal.** Removal of excess skin due to excision of fat removal, unless pre-approved by Medical Directors.

42. **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

43. **Speech Therapy.** Charges for speech therapy, except as specified in the Medical Plan Covered Services section of the Summary Plan Description.

44. **Sports.** Functional improvements for athletics, including, but not limited to, surgery, devices, or injections for improved athletic performance.

45. **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

46. **Tobacco cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under the Affordable Care Act, including smoking deterrent products, but not including electronic cigarettes.

47. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge. Also excludes charges for, but not limited to, convenience items related to travel that would not be necessary in similar situations within your own home, such as travel-size cpap or oxygen machines.

48. **Video or Teleconference.**

49. **Vision Therapy.** Charges for vision therapy, except as specified in the Medical Plan Covered Services section of the Summary Plan Description or approved by Medical Directors and member is active participant in Chronic Disease Case Management.

50. **War or Bioterrorism.** Any loss that is due to a declared or undeclared act of war or bioterrorist prevention, such as but not limited to, immunizations, medications, supplies or other related services.

51. **Weight Loss Surgery.** Weight loss surgery, unless pre-approved by Medical Directors.

BASIC MEDICAL PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan Exclusions list.

For all Medical Benefits shown in the Schedule of Medical Benefits or Medical Plan Covered Services sections of the Summary Plan Description, a charge for the following is not covered:

1. **Abortion.** Charges for elective induced abortions, except for in the cases of rape, incest or maternal endangerment.

2. **Alcohol or Substance Impairment.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of alcohol or other substances causing impairment. Expenses will be covered for Injured Covered Persons other than the person using alcohol or substances causing impairment. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

3. **Biofeedback.**

4. **Blepharoplasty.**

5. **Breast or penile implants.** Coverage for breast or penile implants except for reconstructive surgery following mastectomy.

6. **Breast reduction or mammoplasty.**

7. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

8. **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, tattoos or body piercings or removals of such items (including complications from either the applying or removing of such items), or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by Injury, disease, trauma, congenital/developmental anomalies, or previous covered therapeutic processes.

9. **Custodial care.** Services or supplies of a custodial care or domiciliary nature such as those normally provided at health resorts, rest homes, nursing homes, health spas, and convalescent centers. Also, services that are primarily educational in nature or any maintenance-type care which is not reasonably expected to improve the patient’s condition (except Hospice care as specified).

10. **Dental.** Services, supplies, care or treatment of dental or oral charges. Charges will be covered only to the extent specifically set forth in the Medical Plan Covered Services section of the Summary Plan Description and only within the Gulf Coast Provider Network. Dental extractions are not covered unless approved by the Medical Directors and member is active participant in Chronic Disease Case Management.

11. **Educational or vocational testing**. Services for educational or vocational testing or training.

12. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

13. **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for routine patient care of costs a Qualified Individual who is a participant in an approved clinical trial. Charges will be covered only to the extent specifically set forth in the Medical Plan Covered Services section of the Summary Plan Description and only within the Gulf Coast Provider Network.

14. **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

15. **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, bunionectomy, hammertoe surgery, and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

16. **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

17. **Gene Therapy.** Care, treatment, or supplies for gene therapy or genetic testing and fetal treatment except to the extent specifically set forth in the Medical Plan Covered Services section of the Summary Plan Description or per Health Plan Medical Directors.

18. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

19. **Growth Hormones.**

20. **Gynecomastia.** Surgical care or treatment for gynecomastia.

21. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy up to the limit shown in the Medical Plan Covered Services section of the Summary Plan Description.

22. **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of , but not limited to, hazardous hobbies or activities are skydiving, auto or motor cross racing, motorcycle riding without a helmet, boat racing, hang gliding, parasailing, or bungee jumping.

23. **Hearing related evaluations or treatments.** Charges for services or supplies in connection with hearing aids or exams for their fitting, including but not limited to, cochlear implants or any surgical procedure for hearing unless approved by Medical Directors and member is active participant in Chronic Disease Case Management.

24. **Holistic or homeopathic medicine.**

25. **Hypnotherapy.** Charges for service or supplies in connection with hypnotherapy or hypnotism or any type of goal-oriented or behavior modification therapy, such as to quit smoking or lose weight.

26. **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

27. **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

28. **Infertility.** Charges or supplies for artificial insemination; in-vitro fertilization procedures or drugs, GIFT (Gamete IntraFallopian Transfer) procedures, studies, or drugs related to the treatment of infertility. Also excludes any charges relating to surrogacy, including, but not limited to, delivery charges.

29. **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

30. **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

31. **Emergency treatment for non-emergent conditions.** Emergency care and treatment billed by a Hospital or Facility for non-emergent conditions.

32. **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

33. **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

34. **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

35. **Obesity.** Screening and counseling for obesity will be covered to the extent required under Standard Preventive Care. Other care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness is excluded.

Also excluded is removal of excess skin due to weight loss or excision of fat removal, unless pre-approved by Medical Directors.

36. **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

37. **Occupational Therapy.** Charges for occupational therapy, except as specified in the Medical Plan Covered Services section of the Summary Plan Description.

38. **Pain treatment.** Charges or supplies for pain treatment other than oral medications.

39. **Pectus excavatum repair.**

40. **Penile dysfunction.** Care, supplies or treatment for penile dysfunction.

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

42. **Plan design exclusions.** Charges excluded by the Plan design as mentioned in this document.

43. **Plasmapheresis.**

44. **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

45. **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or the device is no longer functional.

46. **Rhinoplasty/Rhytidectomy.**

47. **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Medical Benefits or required by applicable law.

48. **Sclerotherapy or surgery for varicose veins.**

49. **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

50. **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

51. **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

52. **Skin removal.** Removal of excess skin due to excision of fat removal, unless pre-approved by Medical Directors.

53. **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

54. **Sleep studies.**

55. **Speech Therapy.** Charges for speech therapy, except as specified in the Medical Plan Covered Services section of the Summary Plan Description.

56. **Sports.** Functional improvements for athletics, including, but not limited to, surgery, devices, or injections for improved athletic performance.

57. **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

58. **Tobacco cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under the Affordable Care Act, including smoking deterrent products, but not including electronic cigarettes.

59. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge. Also excludes charges for, but not limited to, convenience items related to travel that would not be necessary in similar situations within your own home, such as travel-size cpap or oxygen machines.

60. **Uvulopalatopharyngoplasty.** Care and treatment for uvulopalatopharyngoplasty including laser assisted procedures.

61. **Travel related care for international travel.**

62. **Video or Teleconference.**

63. **Vision Therapy.** Charges for vision therapy, except as specified in the Medical Plan Covered Services section of the Summary Plan Description or approved by Medical Directors and member is active participant in Chronic Disease Case Management.

64. **War or Bioterrorism.** Any loss that is due to a declared or undeclared act of war or bioterrorist prevention, such as but not limited to, immunizations, medications, supplies or other related services.

65. **Weight Loss Surgery**.

PRESCRIPTION BENEFITS

Prescription Benefit Limitations

There are three different prescription plans: **Comprehensive RX, Basic RX** and **Extended RX.** Each has an annual limit on the portion of pharmacy costs paid by SMHCS. A pharmacy case manager is available to help Participants in these Plans stay within the limits of the maximum expenses allowed. The limit will increase by an additional $1,000 for Plan Participants who work with a pharmacy case manager and their Physicians to consider appropriate medication substitutions. You may contact the pharmacy case manager at www.gulfcoastmemberservices.org or (941) 917-1473 for more details or assistance with this program. After the increased annual limit has been reached, Plan Participants are responsible for an additional $1,000 of prescription expenses, after which the Plan covers the remaining prescription costs with a 50% co-insurance for Participants in the Comprehensive RX and Basic RX Plans. Please note that the 50% co-insurance coverage that begins after the coverage gap is not capped by a per-prescription maximum. After the Extended RX Plan annual limit has been reached and the Participant continues to work with the pharmacy case manager, the Plan will cover the remaining prescription costs with a 60% co-insurance and the Participant would be responsible for 40%. If the Participant also works with the Chronic Disease Case Manager, the Plan will cover the remaining prescription costs at 80%. If the Participant does not work with the Pharmacy Case Manager and/or Chronic Disease Case Manager, the employee would be responsible for a 50% co-insurance.

Mail Order Program for Maintenance Drugs

(up to a 90-day supply)

The Mail Order Program is available for brand and generic maintenance medications to be delivered to Participants' door. Mail order service is recommended only for maintenance medications, rather than medications that will only be needed on a short-term basis (e.g. antibiotics for an acute illness). Maintenance medications are typically used to treat chronic, long-term conditions.

90-Day Medication Supply Retail Program

Prescriptions for maintenance medications may also be filled at a participating retail pharmacy in the Navitus Health Solutions network (www.Navitus.com).

Some examples of maintenance medications include:

Anti-Arthritics
Anti-inflammatory agents
Colchicine agents
Purine inhibitors
Urlocosuric agents
Anti-Asthmatics
Xanthines
Anti-Coagulants
Oral anti-coagulants
coumaria type
Antidepressants
Anti-Glaucomatous
Agents
Mydriatics
Miotics & other pressure
reducers
Anti-Mania
Anti-Narcolepsy/Anti-
Hyperkinesis Agents
Anti-Parkinson
Anti-Seizure
Barbiturates
Anti-Tubercular
Agents and antibiotics
Cardiovascular
Adrenergic inhibitors
ldosterone antagonists
Hypotensive agents
Inotropic drugs
Cardiac Drugs
Coronary vasocilators
Digitalis Glycosides
Anti-Arrhythmic
Beta-adrengic blocking
agents
Calcium channel blockers
Peripheral vasodilators
Diabetic Therapy
including insulin, syringes, test
strips and lancets
Oral hypoglycemic agents
Sulfonylurea type
Diuretics
Thiazide diuretics & related
agents
Potassium sparing diuretics
Carbonic anhydrous inhibitors
Hormones
Estrogenic agents
Progestoroneal agents
Oral Contraceptives
Potassium Replacement
Thyroid Supplements
Thyroid hormones
Anti-thyroid preparations
Ulcer Medications
Proton Pump Inhibitors

Prescription Plan Definitions

Generic Drugs A drug that is no longer limited to manufacture by a single producer due to expiration of patent protection. By law, generic drugs must meet the Food & Drug Administration's guidelines for purity, strength and safety and must produce the same effect in the body and have the same active ingredients as brand name drugs.

Formulary Drugs "Preferred" brand-name drugs selected based on their ability to meet patient needs at a lower cost.

Brand Name Drugs Drugs for which there is no generic substitute.

Generic Substitution

Unless otherwise noted by the Physician, each prescription and each refill will be filled with a Generic Prescription Drug, if there is a generic equivalent available, with the exception of any product requiring utilization of a brand product. When a Generic Prescription Drug is available but a non-generic drug is dispensed *for any reason*, the covered person must pay the generic co-payment plus the difference between the generic and the non-generic price. Prescription Drugs without a generic equivalent are subject to the listed brand co-insurance.

Step Therapy

To effectively manage both single-source and multi-source brands, step therapy requires that a cost effective lower cost alternative is tried first before targeted single source brand medications. Mandatory rules steer Members to lower cost alternatives. See more details at www.gulfcoastmemberservices.org under Pharmacy Case Management.

Covered Charges

- Insulin; and insulin needles/syringes, chemstrips and lancets by prescription only;
- Compound medications, excluding bulk chemicals, in which at least one ingredient is a Prescription Legend Drug;
- Other drugs or medicines (other than those listed in the "Limitations" section below that can be legally dispensed only upon the written prescription of a Physician).
- Growth Hormones, Retin-A, and amphetamines are covered only with pre-authorization from Medical Management.
- Family planning drugs or medicines that are FDA approved contraceptive methods and are Preventive Services/Care, including the following:
  - Oral contraceptives:
    - Formulary generic and some formulary brands without a generic alternative oral contraceptives covered at no cost
    - Formulary brand oral contraceptives covered at applicable co-pay and/or deductible, step therapy applies
  - Spermicides: over the counter covered at no cost with a prescription
  - Injections:
    - Formulary generic and some formulary brands without a generic alternative covered at no cost
    - Formulary brand covered at applicable co-pay and/or deductible, step therapy applies
  - Patch:
    - Formulary generic and some formulary brands without a generic alternative covered at no cost
    - Formulary brand covered at applicable co-pay and/or deductible; step therapy applies
  - Vaginal ring:
    - Formulary generic and some formulary brands without a generic alternative covered at no cost
    - Formulary brand covered at applicable co-pay and/or deductible; step therapy applies

Prescription Pre-Authorizations

Specialty Drugs
Pre-authorization requirements are placed on certain non-specialty and specialty medications to increase appropriate use of certain drugs. Navitus Health Solutions must pre-authorize prescriptions for specialty medications with your Physician prior to filling them. Navitus SpecialtyRx is a specialty pharmacy program offered through a partnership with Walgreens Specialty Pharmacy that helps manage high-cost and injectable drugs with a focus on patient care. Call Walgreen's dedicated Specialty phone at 941-260-7001.

Schedule Of Prescription Benefits

Limitations	***Comprehensive Plan***	***Basic Plan***	***Extended Plan***
Base Benefit (Net Cost to SMHCS)	*$3,000*	*$2,000*	*$7,000*
Additional Benefit Amount of Coverage if Pharmacy Case Management is Utilized	*$1,000*	*$1,000*	*$1,000*
Coverage Gap Per Participant (After base benefit and additional benefit has been reached)	*$1,000*	*$1,000*	*$1,000*
Umbrella Coverage Co-insurance (Begins after coverage gap has been met)	*50/50 (No per script maximum)*	*50/50 (No per script maximum)*	*50/50 With a Pharmacy Case Manager: 60/40. With a Pharmacy Case Manager and Chronic Disease Case Manager: 80/20 with maximum $300 per prescription.*
Mandatory Generic (and certain lower-cost preferred brand) Substitution	Yes	Yes	Yes
Mandatory Mail Order on Maintenance Drugs	No	No	No
Retail Benefits (30 day supply)			
Tier 1 Preferred generics and some lower cost brand products	$9	$9	$9
Tier 2 Preferred brand products and some high cost non-preferred generics	60/40 ($25 minimum per script, $75 maximum per script)	60/40 ($25 minimum per script, $75 maximum per script)	60/40 ($25 minimum per script, $100 maximum per script)

Limitations	***Comprehensive Plan***	***Basic Plan***	***Extended Plan***
Tier 3 Non-preferred products (may include some high cost non-preferred generics)	40/60 ($35 minimum per script, $75 maximum per script)	40/60 ($35 minimum per script, $75 maximum per script)	40/60 ($35 minimum per script, $100 maximum per script)
30 day supply in Tier 3 if lower tier option is available	$150 Max per script, plus Tier 1 co-pay, if you or your Provider choose **not** to substitute with the available lower cost alternatives including scripts that are medical necessity (see Step Therapy paragraph on page 61).	$150 Max per script, plus Tier 1 co-pay, if you or your Provider choose **not** to substitute with the available lower cost alternatives including scripts that are medical necessity (see Step Therapy paragraph on page 61).	$150 Max per script, plus Tier 1 co-pay, if you or your Provider choose **not** to substitute with the available lower cost alternatives including scripts that are medical necessity (see Step Therapy paragraph on page 61).
Tier 4 Specialty Drugs	$100 **Specialty drugs may require participation in a specialty drug program**	$100	$100
Compound Drugs *Compounds with a cost greater than $400 require a Compounded Drugs pre-authorization*	Single source compounds: Non-brand 40% of the cost, not to exceed $60 Brand copay $100; $400 limit per 30 day supply	Single source compounds: Non-brand 40% of the cost, not to exceed $60 Brand copay $100; $400 limit per 30 day supply	Single source compounds: Non-brand 40% of the cost, not to exceed $60 Brand copay $100; $400 limit per 30 day supply
Retail Benefits (90 day supply)			
Tier 1 Preferred generics and some lower cost brand products	$20	$20	$20
Tier 2– Preferred brand products and some high cost non-preferred generics	60/40 ($50 minimum per script; $75 maximum per script)	60/40 ($50 minimum per script; $75 maximum per script)	60/40 ($50 minimum per script; $100 maximum per script)
Tier 3 Non-preferred products (may include some high cost non-preferred generics)	40/60 ($75 minimum per script; $75 maximum per script)	40/60 ($75 minimum per script; $75 maximum per script)	40/60 ($75 minimum per script; $100 maximum per script)
Tier 4 Specialty Drugs	Not Available	Not Available	Not Available

Limitations	***Comprehensive Plan***	***Basic Plan***	***Extended Plan***
Mail Order Benefits (90 day supply)			
Tier 1 Preferred generics and some lower cost brand products	$20	$20	$20
Tier 2 Preferred brand products and some high cost non-preferred generics	60/40 ($50 minimum per script, $75 maximum per script)	60/40 ($50 minimum per script, $75 maximum per script)	60/40 ($50 minimum per script, $100 maximum per script)
Tier 3 Non-preferred products (may include some high cost non-preferred generics)	40/60 ($75 maximum per script)	40/60 ($75 maximum per script)	40/60 ($100 maximum per script)
90 day supply in Tier 3 if lower tier option is available — applies to both retail and mail order	$150 Max per script, plus Tier 1 co-pay, if you or your Provider choose **not** to substitute with the available lower cost alternatives including scripts that are medical necessity (see Step Therapy paragraph on page 61).	$150 Max per script, plus Tier 1 co-pay, if you or your Provider choose **not** to substitute with the available lower cost alternatives including scripts that are medical necessity (see Step Therapy paragraph on page 61).	$150 Max per script, plus Tier 1 co-pay, if you or your Provider choose **not** to substitute with the available lower cost alternatives including scripts that are medical necessity (see Step Therapy paragraph on page 61).
Tier 4 Specialty Drugs	Not Available	Not Available	Not Available
Family Planning - FDA approved contraceptive methods that meet the definition of Preventive Services/Care	Covered at 100%	Covered at 100%	Covered at 100%

PRESCRIPTION PLAN EXCLUSIONS

Note: All exclusions related to Medical Plans are shown in the "Basic Medical Plan Exclusions" or the "Comprehensive and Extended Medical Plan Exclusions" lists.

For all Prescriptions shown in the Schedule of Prescription Benefits or Prescription Benefits sections of the Summary Plan Description, in addition to the General Limitations of this Plan, no payment will be made under any portion of this Plan for charges incurred for:

- Non-FDA approved drugs, dosage forms, strengths or indications/uses; or
- Drugs or medicines that are not for Medically Necessary care;
- Over-the-counter (OTC) drugs and drugs with OTC equivalents, other than insulin;
- Non-prescription drugs unless recommended by the Physician, reviewed by the Pharmacy Case Manager and with a Physician Prescription;
- Charges for drugs, medicines, or supplies which do not require a prescription for purchase, including but not limited to vitamins, mineral supplements, and fluoride drugs;
- Prescriptions covered under Worker's Compensation;
- Charges for the administration or injection of any drug;
- Therapeutic devices or appliances, including support garments, and other non-medicinal substances, regardless of intended use;
- Medication which is to be taken by or administered to a Covered Person, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals to the extent such medications are already covered under the Medical Plan;
- Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order;
- Replacements for lost or stolen prescriptions;
- Fertility drugs;
- Special Diets;
- Vitamins (other than prenatal) and nutritional supplements;
- Immunization agents, biological sera, blood or blood plasma;
- Drugs labeled "Caution-limited by federal law to investigational use," or Experimental drugs, even though a charge is made to the Covered Person.
- Steroids for body building;
- CII, CIII, Benzodiazepine, and Hypnotics delivered or administered by the prescriber;
- CII, CIII, Benzodiazepine, and Hypnotics prescribed or dispensed by any person in your Immediate Family or any person in your Dependent's Immediate Family;
- Any prescription directing pre-natal administration or use (in-utero treatment);
- Drugs or medicines for which you or your Dependent have no financial liability or that would be provided at no charge in the absence of coverage;
- Drugs or medicines paid for or furnished by the US government or one of its agencies (except as required under Medicaid provisions of federal law);
- Drugs or medicines provided as a result of sickness or Injury due to war or an act of war or to voluntary participation in criminal activities.
- Injectables other than Insulin, Anticoagulants, Epi-pen, and specialty medications
- Compound drugs that include bulk chemicals

Payment of Prescription Drug Benefits

If you purchase your prescriptions from a Network Pharmacy, you should present your medical/RX ID card to the pharmacist with your prescription when your prescription is filled or refilled.

If you buy your prescription drugs from a non-Network pharmacy, you should:

- Pay the pharmacist the entire cost of the prescription;
- Obtain a prescription claim form from SMHCS or Navitus;
- Complete your portion of the claim;
- Mail the completed form and receipts to this address:

  Navitus Health Solutions, LLC
  P.O. Box 999
  Appleton, WI 54912-0999
  OR
  Fax
  (920)735-5315 / Toll Free (855)668-8550

- The covered benefit amount will be paid directly to you from Navitus.
- Note that if you use a non-Network pharmacy, your benefit will be reimbursed at the Network pharmacy negotiated rate less any applicable co-payments. The Participant must pay the difference between the negotiated rate and the actual cost plus the appropriate co-payment.

Mail Order Drug Program

To receive prescriptions through the mail order program, submit the original prescription with a mail order claim form and payment of the appropriate co-payment amount. If you do not know the amount of your co-payment, call NoviXus at 1-888-240-2211. NoviXus may also be accessed via the internet at www.novixus.com to access updated claims information, order refills, view drug information, or ask questions. You may also call the Pharmacy Case Manager at 941-917-1473.

Pharmacy Case Management

Pharmacy case management is available anytime of the year at no cost to you. We can help manage your medication costs by reviewing your medications. Our Pharmacy Case Manager will offer possible alternatives from the preferred Navitus formulary. We will discuss other possible cost saving suggestions.

There is a form available for NEW employees to submit to help you “pick a plan.” New employees are encouraged to contact the Pharmacy Case Manager prior to picking your pharmacy plan.

For more information please fill out the form at www.gulfcoastmemberservices.org , choose pharmacy case manager, and scroll to the middle of the page and click on the icon with the BIG RED star. Fill out the form and submit. The Pharmacy Case Manager will get back to you within 72 hours. There is a form for NEW employees to submit.

COORDINATION OF BENEFITS

If a Covered Person is covered under more than one group plan, including this Plan and any other group medical benefits provided through or by the Employer, and one or more other plans, as defined below, benefits will be coordinated. The benefits payable under this Plan for any Claim Determination Period will be either its regular benefits or reduced benefits which, when added to the benefits of the other plan, will equal 100% of the Allowable Expenses, also defined below:

Definitions

Allowable Expenses: Any Medically Necessary Covered Service rendered to a Covered Person which is covered at least in part under this Plan.

Claim Determination Period: A Calendar or Plan Year or that portion of a Calendar or Plan Year during which the Covered Person for whom claim is made has been covered under this Plan.

Entitled Individual: A person who is entitled to some or all of the benefits provided by Part A of Medicare. A person shall be considered an Entitled Individual beginning on the earliest date he would have become entitled if he had promptly submitted all applications and proofs required for such benefit protection.

Plan: Any plan under which medical or dental benefits or services are provided by:

1) Group, blanket or franchise insurance coverage;
2) Any group Hospital service prepayment, group medical service prepayment, group practice or other group prepayment coverage;
3) Medicare
4) Any plan arranged through any school, employer, trustees, association, union, or employee benefit association.
5) Coverage under governmental programs or coverage required or provided by any statute (including no-fault auto insurance), except Medicare. (Refer to the **"Special Provisions with Respect to Medicare"** provision for treatment of this coverage under this Plan).
6) Hospital indemnity benefits;
7) Hospital reimbursement-type plans which permit the covered person to elect indemnity benefits at the time of claims.

Effect of Health Maintenance Organization (HMO) Coverage

This Plan will not consider as an Allowable Expense any charge which would have been covered by an HMO had a Covered Person for whom the HMO would be primary payor, used the services of an HMO Participating Provider. Nor will this Plan consider any charge in excess of what an HMO provider has agreed to accept as payment in full.

Coordination with Personal Injury Protection (PIP)

If you or a covered dependent are eligible for a minimum of $10,000 in medical benefits under Florida's No-Fault Personal Injury Protection and you are injured in an automobile accident, No-Fault PIP, by law, pays benefits first.

Special Provisions With Respect to Medicare

In accordance with the Tax Equity Fiscal Responsibility Act of 1982 (TEFRA - P.L. 97-248) and the Deficit Reduction Act (DEFRA - P. L. 98-369), an active Employee or spouse who has attained age 65 and is eligible for Medicare, may elect or reject medical coverage under this Plan. If such person elects medical coverage under this Plan, the benefits of this Plan will generally be determined before any benefits provided by Medicare (i.e., this Plan will pay its benefits first, and then the claims may be

submitted to Medicare for consideration). Covered Persons should be certain to enroll in Medicare in a timely manner to assure maximum coverage.

There may be an instance when, in accordance with Federal law, this Plan may assume a secondary position to Medicare (i.e., Medicare will determine its liability first). If this should occur, this Plan reserves the right to assume the secondary position, and benefits will be reduced by amounts paid or payable by Medicare. In such instance, if the Claimant is eligible for Medicare, he will be deemed to be covered by Medicare Part A, whether or not he has actually enrolled for Part A. Also, he will be deemed to be covered by Medicare as of the earliest date any Medicare coverage could have been effective had he applied in a timely manner. Covered Persons should be certain to enroll in Medicare Part A coverage in a timely manner to assure maximum coverage.

NOTE: If a Medicare-eligible Employee rejects coverage under the Plan, no Plan coverage will be available for any of his Dependents.

Employment Status	***Medicare-eligible participants will be assumed to be Medicare enrolled and benefits will be administered accordingly.***
Active Employee< 65	Plan primary
Retired Employee < 65	Plan primary
Active Employee 65 or over	Plan primary, Medicare may be secondary
Retired Employee 65 or over	Medicare primary, plan secondary

Order of Benefit Determination

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the Allowable Expenses. No plan pays more than it would without the Coordination of Benefits Provision.

A plan without a Coordination of Benefits provision is always the primary plan. If all plans have such a provision:

1. The plan covering the person directly, rather than as an employee's dependent, is primary and the others are secondary.

2. Dependent children of parents not separated or divorced: the plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second.

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

3. Dependent children of separated or divorced parents: When parents are separated or divorced, neither the male/female nor the birthday rules apply. Instead:

   a. The plan of the parent with custody pays first;
   b. The plan of the spouse of the parent with custody (the step-parent) pays next; and
   c. The plan of the parent without custody pays last.

   However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses and the insurer or other entity obliged to pay or provide the benefit of that parent's plan has actual knowledge of those terms, that plan pays first. If any benefits are

actually paid or provided before that entity has actual knowledge, this "court decree" rule is not applicable during the remainder of the Plan Year.

4. Active/Inactive Employee: The plan covering a person as an employee who is neither laid off nor retired (or as that person's dependent) pays benefits first. The plan covering that person as a laid off or retired employee (or as that person's dependent) pays benefits second. If both plans do not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

5. If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.

Coordination of Benefits may operate to reduce the total amount of benefits otherwise payable during any Claim Determination Period with respect to a Covered Person under this Plan. When the benefits of this Plan are reduced, each benefit is reduced proportionately. The reduced amount is then charged against any applicable benefit limit of this Plan.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Allowable Expense and a benefit paid.

Recovery

If the amount of the payment made by this Plan is more than it should have paid, the Plan has the right to recover the excess from one or more of the following:

1. The person this Plan has paid or for whom it has paid;
2. Insurance companies;
3. Other organizations.

Payment to Other Carriers

Whenever payments, which should have been made under this Plan in accordance with the above provisions, have been made under any other plans, this Plan will have the right exercisable alone and in its sole discretion to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, this Plan will be fully discharged from liability.

Release of Information

For the purpose of determining the applicability of and implementing the terms of the above provisions of this Plan or any similar provision of another plan, the Third Party Administrator may, without the consent of or notice to any Covered Person, release to or obtain from any other insurance company or other organization or individuals, any information concerning any Covered Person, which is necessary for those purposes.

Any person receiving benefits under this Plan must furnish to the Third Party Administrator information about other coverage which may be involved in applying this Coordination of Benefits provision.

FLEXIBLE BENEFIT PLAN

Premium Payment Benefits

The Premium Payment Benefits allow you to pay for your share of contributions for the Medical Plan and other Benefit Options with pre-tax dollars by entering into a Salary Reduction Agreement with your Employer. When you enroll, you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. You then pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis.
Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

You may elect to pay for the following benefits with pre-tax dollars:

- medical plan (currently offering basic, comprehensive, and extended coverage options)
- dental plan
- vision plan
- health fsa
- dependent care fsa
- life insurance
- long-term disability

The Employer may contribute all, some, or no portion of the Premium Payment Benefits that you have selected, as described in documents furnished separately to you.

Health FSA Benefits

A Health FSA permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Medical Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from the Medical Plan). If you elect Health FSA Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not reimbursed elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

Health FSA Account

If you elect Health FSA Benefits, then an account called a “Health FSA Account” will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your Health FSA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest. This FSA Program does not have a debit card. A paper form and original documentation are required for reimbursement.

Maximum and Minimum Health FSA Benefits

You may choose any amount of Medical Care Expenses reimbursement that you desire under the Health FSA, subject to the minimum and maximum reimbursement amounts specified by the Plan Administrator. Per current IRS statutory limits, the minimum reimbursement amount is $10 and the maximum reimbursement amount is $2,550. You will be required to pay the annual Health FSA contribution equal to the coverage level that you have chosen.

Paying for Health FSA Benefits

When you enroll, you specify the amount of Health FSA Benefits that you wish to pay for with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis. For example, suppose that you have elected to be reimbursed up to $1,000 per year for Medical Care Expenses and that you have chosen no other benefits under the Plan. If you pay all of your contributions, then your Health FSA Account would be credited with a total of $1,000 during the Plan Year. If you are paid bi-weekly, then your Health FSA Account would reflect that you have paid $38.46 ($1,000 divided by 26) each pay period in contributions for the Health FSA Benefits that you have elected.

The Employer makes no contribution to your Health FSA Account.

Health FSA Reimbursement

The full amount of Health FSA coverage that you have elected (reduced by prior reimbursements made during the same Plan Year) will be available to reimburse you for qualifying Medical Care Expenses incurred during the Plan Year, regardless of the amount that you have contributed when you submitted the claim (so long as you have continued to pay the contributions). For example, suppose that you elected $1,000 of coverage and contributed to your Health FSA Account during January and February - that means that by February 24 you would have contributed $153.84 ($38.46 times four pay periods). You haven't made any prior claims for reimbursement during the calendar year, but on February 26 you incur a Medical Care Expense in the amount of $300. You submit that claim for reimbursement on February 27. So long as the claim meets all applicable requirements, the $300 would be available to you for that expense, even though you have only contributed $153.84 to your Health FSA Account at that point. If you have insurance for items that are being requested to be reimbursed, you must provide documentation of the actual portion covered by insurance. Estimated coverage amounts by insurance are unable to be accepted.

Medical Care Expenses

Medical Care Expenses means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code §213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise, or eligible to be reimbursed through insurance or otherwise. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical or Dental Insurance Plan imposes co-payment or deductible limitations), then the Health FSA can reimburse the remaining portion of such Medical Care Expense if it otherwise meets the requirements of this Section. Notwithstanding the foregoing, the term Medical Care Expenses does not include:

- premium payments for other health coverage, including but not limited to health insurance premiums for any other plan (whether or not sponsored by the Employer);
- medicines or drugs, unless the medicine or drug is a prescribed drug (determined without regard to whether the medicine or drug is available without a prescription) or is insulin (for this purpose, the Plan Administrator shall have sole discretion to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug and whether the requirement of a prescription has been satisfied);
- cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease (for this purpose, "cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease); or
- any other expense excluded under the Medical Plan Exclusions or otherwise under the terms of this Plan.

The Plan Administrator may promulgate procedures regarding the eligibility of various expenses for reimbursement as Medical Care Expenses and may limit reimbursement of expenses described in such procedures.

The following expenses are not eligible Medical Care Expenses:

- Health insurance premiums for any other plan (including a plan sponsored by the Employer)
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home
- Funeral and burial expenses
- Household and domestic help (even if recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).
- Custodial care
- Educational expenses
- Social activities or health club memberships (even if recommended by a physician for general health improvement)
- Bottled water
- Cosmetics, toiletries, toothpaste, and other personal hygiene items
- Uniforms or special clothing, such as maternity clothing
- Automobile insurance premiums
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician
- Any item that does not constitute "medical care" as defined under Code § 213(d)
- Any item that is not reimbursable under applicable regulations

For more information about what items are—and are not—Medical Care Expenses, consult IRS Publication 502 ("Medical and Dental Expenses") under the headings "What Medical Expenses Are Deductible?" and "What Expenses Are Not Deductible?" But use the Publication with caution, because it was meant only to help taxpayers figure out what medical expenses can be deducted on the Form 1040 Schedule A (i.e., to figure out their tax deductions), not what is reimbursable under a Health FSA. In fact, some of the statements in the Publication aren't correct when determining whether that same expense is reimbursable from your Health FSA. This is because there are several fundamental differences between what is deductible as medical care (under Code §§ 213(a) and 213(b)) and what is reimbursable as medical care under a Health FSA (under Code §213(d)). Not all expenses that are deductible are reimbursable under a Health FSA. (For example, health insurance premiums, founders' fees, lifetime care, long-term contracts, and long-term care services are listed as deductible expenses in Publication 502, but generally they cannot be reimbursed from your Health FSA). And not all expenses that are reimbursable under a Health FSA are deductible.

Ask the Plan Administrator if you need further information about which expenses are—and are not—likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Medical Care Expenses Must be Incurred during Plan Year

For Medical Care Expenses to be reimbursed to you from your Health FSA Account for the Plan Year, they must have been incurred during that Calendar Plan Year. The Plan Year for the Health FSA is the 12-month period beginning on January 1 and ending on December 31.

A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for medical

care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the Health FSA or the Plan became effective, before your election became effective, for any expense incurred before the start of the Plan Year or after the close of the Plan Year, or after a separation from service (except for Continuation Coverage).

Reimbursement of Medical Care Expenses from the Health FSA

When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator on a Health FSA Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred and stating the amount of such Medical Care Expenses, along with the Health FSA Reimbursement Request Form. Generally, this requires including an Explanation of Benefits (EOB) Form from the medical insurance carrier (or a bill from a doctor's office) indicating the amounts that you are obligated to pay. Further details about what must be provided are contained in the Health FSA Reimbursement Request Form.

If you have paid the contributions for the Health FSA coverage that you have elected, then you will be reimbursed for your eligible Medical Care Expenses within approximately 30 days after the date you submitted the Health FSA Reimbursement Request Form. Claims will be paid in the order in which they are approved. Remember, though, that you can't be reimbursed for any total expenses above the annual reimbursement amount that you have elected.

You will have until March 31st after the end of the Plan Year in which to submit a claim for reimbursement for Medical Care Expenses incurred during the previous Plan Year. Note that it is not necessary for you to have actually paid the amount due for a Medical Care Expense - only for you to have incurred the expense and that it is not being paid for or reimbursed from any other source.

Risk of Losing or Forfeiting the Amounts Elected for Health FSA Benefits

If the Medical Care Expenses that you incur during the Plan Year are less than the annual amount that you elected for Health FSA Benefits, you will forfeit the rest of that amount—this is called the "use-it-or-lose-it" rule under applicable tax laws. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Medical Care Expenses during the Plan Year, even if amounts are still left in your Health FSA Account.

You will forfeit any amounts in your Health FSA Account that are not applied to pay expenses submitted by March 31st following the end of the Plan Year for which the election was effective. Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the Health FSA during the Plan Year and subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. Also, any Health FSA Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

Taxation of Health FSA Benefits

Generally, you will not be taxed on your Health FSA Benefits, up to the statutory limit. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, your Medical Care Expenses must meet the definition of "medical care" as defined in the Code. If you are reimbursed for a claim that is later determined not to be for Medical Care Expenses, then you will be required to repay the amount.

Ultimately, it is your responsibility to determine whether any reimbursement under the Health FSA constitutes Medical Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are - and are not - likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Dependent Care FSA Benefits

A Dependent Care FSA permits eligible Employees to pay for coverage with pre-tax dollars that will reimburse them for Dependent Care Expenses not reimbursed elsewhere (for example, you cannot be reimbursed for the same expense from your Spouse's Dependent Care FSA). If you elect Dependent Care FSA Benefits, then you will be able to provide a source of pre-tax funds to reimburse yourself for your eligible Dependent Care Expenses. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

Dependent Care FSA Account

If you elect Dependent Care FSA Benefits, an account called a "Dependent Care FSA Account" will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the contributions that you have paid for such benefits during the Plan Year. Your Dependent Care FSA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest. This FSA Program does not have a debit card. A paper form and original documentation are required for reimbursement.

Maximum and Minimum Dependent Care FSA Benefits

You may choose any amount of Dependent Care Expenses reimbursement that you desire under the Dependent Care FSA, subject to the minimum reimbursement amount of $10 and the maximum reimbursement amount described below. You must commit to a salary reduction to pay the annual Dependent Care FSA contribution equal to the coverage level that you have chosen (e.g., if you elect $3,000 in Dependent Care FSA Benefits, you'll pay for the benefits with a $3,000 salary reduction).

The amount of Dependent Care Expense reimbursement that you choose cannot exceed $5,000 for a calendar year or, if lower, the maximum amount that you have reason to believe will be excludable from your income under Code §129 when your election is made. The $5,000 maximum will apply to you if:

- you are married and file a joint federal income tax return;
- you are married and file a separate federal income tax return, and meet the following conditions: (1) you maintain as your home a household that constitutes (for more than half of the taxable year) the principal place of abode of a Qualifying Individual (i.e., the Dependent for whom you are eligible to receive reimbursements under the Dependent Care FSA); (2) you furnish over half of the cost of maintaining such household during the taxable year; and (3) during the last six months of the taxable year, your Spouse is not a member of such household (i.e., your Spouse maintained a separate residence); or
- you are single or the head of the household for federal income tax purposes.

If you are married and reside with your Spouse but you file a separate federal income tax return, then the maximum Dependent Care FSA Benefit that you may exclude from your income under Code §129 is $2,500 for a calendar year.

These maximums ($5,000 or $2,500 for a calendar year, as applicable) are just the largest amount that is possible; the maximum amount that you are able to exclude from your income may be less because of other limitations (for example, note that you cannot exclude more than the amount of your or your Spouse's earned income for the calendar year).

Paying for Dependent Care FSA Benefits

When you enroll, you specify the amount of Dependent Care FSA Benefits that you wish to pay with your salary reduction. From then on, you must pay a contribution for such coverage by having that portion

deducted from each paycheck on a pre-tax basis. If you pay all of your contributions, then your Dependent Care FSA Account will be credited with the portion of your gross income that you have elected to give up through salary reduction. These portions will be credited as of each pay period.

For example, suppose that you have elected to be reimbursed for $2,600 per year for Dependent Care Expenses and that you have chosen no other benefits under the Plan. Your Dependent Care FSA Account would be credited with a total of $2,600 by the end of the Plan Year. If you are paid biweekly, then your Dependent Care FSA Account would reflect that you have paid $100 ($2,600 divided by 26) each pay period in contributions for the Dependent Care FSA Benefits that you have elected.

The Employer makes no contribution to your Dependent Care FSA Account.

Dependent Care FSA Reimbursement

The amount of coverage that is available for reimbursement of qualifying Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your Dependent Care FSA Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year. For example, suppose that you incur $1,500 of Dependent Care Expenses by the end of March. At that time, your Dependent Care FSA Account would only have been credited with $700 ($100 times seven pay periods), so only $700 would be available for reimbursement at the end of March (assuming that you had not received any prior reimbursements). You would have to wait to submit the remaining $800 in Dependent Care Expenses until after you had received the appropriate credits to your Dependent Care FSA Account (you could request a $100 reimbursement after each of the next eight pay periods).

Dependent Care Expenses

"Dependent Care Expenses" means employment-related expenses incurred on behalf of a person who meets the requirements to be a "Qualifying Individual," as defined in the first bulleted item below. All of the following conditions must be met for such expenses to qualify as Dependent Care Expenses that are eligible for reimbursement:

- Each person for whom you incur the expenses must be a Qualifying Individual—that is, he or she must be:
- a person under age 13 who is your "qualifying child" under the Code (in general, the person must: (1) have the same principal abode as you for more than half the year; (2) be your child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them; and (3) not provide more than half of his or her own support for the year);
- your Spouse who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as you for more than half of the year; or
- a person who is physically or mentally incapable of caring for himself or herself, has the same principal place of abode as you for more than half of the year, and is your tax dependent under the Code (for this purpose, status as a tax dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of the Code's definition).

Under a special rule for children of divorced or separated parents, a child is a Qualifying Individual with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child. See the Plan Administrator for more information on which individuals will qualify as your Qualifying Individuals.

- No reimbursement will be made to the extent that such reimbursement would exceed the balance in your Dependent Care FSA Account.
- The expenses are incurred for services rendered after the date of your election to receive Dependent Care FSA Benefits and during the Plan Year to which the election applies.
- The expenses are incurred in order to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: If

your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or be physically or mentally incapable of self-care.

- The expenses are incurred for the care of a Qualifying Individual or for household services attributable in part to the care of a Qualifying Individual.
- If the expenses are incurred for services outside of your household for the care of a Qualifying Individual other than a person under age 13 who is your qualifying child, then the Qualifying Individual must regularly spend at least eight hours per day in your household.
- If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- The person who provided care was not your Spouse, a parent of your under-age-13 qualifying child, or a person for whom you (or your Spouse) are entitled to a personal exemption under Code §151(c) . If your child provided the care, then he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The expenses are not paid for services outside of your household at a camp where the Qualifying Individual stays overnight.

For more information about what items are—and are not—deductible Dependent Care Expenses, consult IRS Publication 503 ("Child and Dependent Care Expenses") under the heading "Tests to Claim the Credit." But use the Publication with caution, because it was meant only to help taxpayers figure out whether they can claim the household and dependent care services tax credit under Code §21 ("the Dependent Care Tax Credit," discussed further below), not what is reimbursable under a Dependent Care FSA. In fact, some of the statements in the Publication aren't correct when determining whether that same expense is reimbursable under your Dependent Care FSA. This is because there are several fundamental differences between what expenses qualify for the Dependent Care Tax Credit (under Code §21) and what expenses are reimbursable under a Dependent Care FSA (under Code §129). Not all expenses that qualify for the Dependent Care Tax Credit are reimbursable under a Dependent Care FSA. (For example, for an expense to qualify for the Dependent Care Tax Credit in a given year, it must have been paid during that year, but to be reimbursed from the Dependent Care FSA, the expense must have been incurred during the Plan Year for which reimbursement is sought).

Ask the Plan Administrator if you need further information about which expenses are - and are not - likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

You will also be asked to certify that you have no reason to believe that the requested reimbursement, when added to your other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit. Your statutory limit is the smallest of the following amounts:

- your earned income for the calendar year (after your salary reductions under the Plan);
- the earned income of your Spouse for the calendar year (your Spouse will be deemed to have earned income of $250 ($500 if you have two or more Qualifying Individuals) for each month in which your Spouse is (a) physically or mentally incapable of self-care; or (b) a full-time student); or
- either $5,000 or $2,500 for the calendar year, depending on your marital and tax filing status.

Any reimbursements that the Employer has reason to believe will exceed your statutory limit will be subject to FICA and income tax withholding. Note that if you are married and your Spouse also participates in a Dependent Care FSA, the maximum amount that you and your Spouse together can exclude from income is $5,000.

Dependent Care Expenses must be incurred during Plan Year

For Dependent Care Expenses to be reimbursed to you from your Dependent Care FSA Account for the Plan Year, the expenses must have been incurred during that Plan Year. The Plan Year for the Dependent Care FSA is the 12-month period beginning on January 1 and ending on December 31.

A Dependent Care Expense is incurred when the service that causes the expense is provided, not when the expense is paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for dependent care that will be given during the rest of the month, then the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the Dependent Care FSA or Plan became effective, for any expenses arising before your election became effective, for any expenses incurred before the start of the Plan year or after the close of the Plan Year, or after a separation from service.

Reimbursement of Dependent Care Expenses

When you incur an expense that is eligible for payment, you must submit a claim to the Plan Administrator on a Dependent Care FSA Reimbursement Request Form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Dependent Care Expenses have been incurred and stating the amount of such Dependent Care Expenses, along with the Dependent Care FSA Reimbursement Request Form. Further details about what must be provided are contained in the Dependent Care FSA Reimbursement Request Form.

If there are enough credits to your Dependent Care FSA Account, then you will be reimbursed for your eligible Dependent Care FSA Expenses within approximately 30 days after the date you submitted the Dependent Care FSA Reimbursement Request Form. If a claim is for an amount larger than that remaining in your current Dependent Care FSA Account balance, then the excess part of the claim will be carried over into the following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available annual credits to your Dependent Care FSA Account.

You will have until March 31 after the end of the Plan Year in which to submit a claim for reimbursement for Dependent Care Expenses incurred during the previous Plan Year. Note that it is not necessary for you to have actually paid the bill in an amount due for a Dependent Care Expense; only for you to have incurred the expense and that it is not being paid for or reimbursed from any other source.

Risk of Losing or Forfeiting the Amounts Elected

Yes, it is possible to lose or forfeit the amounts you elected. If the Dependent Care Expenses that you incur during the Plan Year are less than the annual amount that you elected for Dependent Care FSA Benefits, you will forfeit the rest of that amount in your Dependent Care FSA Account—this is called the "use-it-or-lose-it" rule under applicable tax laws. In other words, you cannot be reimbursed for (or receive any direct or indirect payment of) any amounts that were not incurred for Dependent Care Expenses during the Plan Year, even if amounts are still left in your Dependent Care FSA Account.

You will forfeit any amounts in your Dependent Care FSA Account that are not applied to Dependent Care FSA Benefits for any Plan Year by the March 31 following the end of the Plan Year for which the election was effective. Forfeited amounts will be used as follows: first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by all Participants; second, to reduce the cost of administering the Dependent Care FSA during the Plan Year and the subsequent Plan Year; and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. Also, any Dependent Care FSA Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

Taxation of Dependent Care FSA Benefits

Generally, you will not be taxed on your Dependent Care FSA Benefits, up to the limits set forth in Q-30. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Dependent Care FSA. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, you will be required to file IRS Form 2441 ("Child and Dependent Care Expenses") with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names and taxpayer identification numbers (TINs) of any entities that provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined not to be for Dependent Care Expenses, then you will be required to repay the amount.

Ultimately, it is your responsibility to determine whether any reimbursement under the Dependent Care FSA constitutes Dependent Care Expenses that qualify for the federal income tax exclusion. Ask the Plan Administrator if you need further information about which expenses are - and are not - likely to be reimbursable, but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Dependent Care Tax Credit

You may not claim any other tax benefit for the amount of your pre-tax salary reductions under the Dependent Care FSA, although your Dependent Care Expenses in excess of that amount may be eligible for the Dependent Care Tax Credit. For example, if you elect $3,000 in coverage under the Dependent Care FSA and are reimbursed $3,000, but you had Dependent Care Expenses totaling $5,000, then you could count the excess $2,000 when calculating the Dependent Care Tax Credit if you have two or more Qualifying Individuals.

The Dependent Care Tax Credit is a credit against your federal income tax liability under the Code. It is a non-refundable tax credit, which means that any portion of it that exceeds your federal income tax liability will be of no value to you. The credit is calculated as a percentage of your annual Dependent Care Expenses. In determining what the tax credit would be, you may take into account $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one Qualifying Individual, or $2,100 for two or more Qualifying Individuals), to a minimum of 20% of such expenses (producing a maximum credit of $600 for one Qualifying Individual, or $1,200 for two or more Qualifying Individuals). The maximum 35% rate is reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) by which your adjusted gross income exceeds $15,000.

Example: Assume that you have one Qualifying Individual for whom you have incurred Dependent Care Expenses of $3,600, and that your adjusted gross income is $20,000. Since only one Qualifying Individual is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is 32%. Thus, your tax credit would be $3,000 x 32% = $960. If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $3,600 x 32% = $1,152, because the entire expense would have been taken into account, not just the first $3,000.

For more information about how the Dependent Care Tax Credit works, see IRS Publication No. 503 ("Child and Dependent Care Expenses"). You may also wish to consult a tax advisor, as discussed below.

For most individuals, participating in a Dependent Care FSA will produce the greater federal tax savings, but there are some for whom the opposite is true. (And in some cases, the federal tax savings from participating in a Dependent Care FSA will be only marginally better). Because the preferable method for

treating benefits payments depends on certain factors such as a person's tax filing status (e.g., married, single, head of household), number of Qualifying Individuals, earned income, etc., each Participant will have to determine his or her tax position individually in order to make the decision. Use IRS Form 2441 ("Child and Dependent Care Expenses") to help you or consult your tax advisor.

TERMINATION OF COVERAGE

Termination of Employee Coverage

A Covered Employee's coverage will terminate immediately upon the earliest date determined in accordance with the following provisions:

- termination of the Plan;
- the date this Plan is amended to terminate the benefits with respect to a covered group of which you are a member;
- the last day of the pay period in which you cease to be an Employee;
- the last day of the pay period in which your active employment with SMHCS is terminated, excluding an approved leave of absence (LOA) that does not extend for more than 6 months or an approved severance period in which benefits continue;
- for an approved leave of absence (LOA) for which active employment ceased, the last day of the pay period in which the LOA ended, up to maximum LOA period of 6 months;
- for an approved severance period during which benefits are agreed by SMHCS to be continued, the last day of the pay period in which severance ends;
- the date the Employee becomes a full-time member of the armed forces of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year. For active duty in the military services of the United States, such date will be the date of active duty on his or her "activation orders." However, if the U.S. active duty call-up is for less than 30 days and is then extended, Plan coverage will continue until 12:00 midnight on the 30th day of active duty;
- termination of regular employment status, such as transferring to a temporary status, except as specified in the **Extension of Coverage** section;
- the end of the period for which the Employee last made the required contribution, if coverage is provided on a contributory basis.

Termination of Dependent Coverage

A Dependent's coverage under the Plan will terminate on the earliest of the following:

- the date the Employee's benefits are terminated;
- the last day of the period for which the last contribution was made, if you are required to contribute and fail to make any required contribution when due;
- the first day of the pay period in which your dependent becomes covered under the Plan as an Employee;
- the last day of the pay period in which your dependent ceases to be a Dependent except as otherwise defined in this handbook;
- the date your dependent enters the armed forces of any country on active, full-time duty;
- the end of the month in which an child Dependent turns 26.

Rescission

If you commit a fraudulent act or intentionally misrepresent a material fact related to the Plan (including submission of a fraudulent claim or misrepresentation of citizenship or immigration status in obtaining or maintaining employment), benefits may terminate retroactive to the date of the fraudulent act or misrepresentation. SMHCS will provide at least 30 days advance written notice prior to the retroactive termination. This paragraph does not apply if you fail to timely pay your premium or contribution towards the cost of coverage or if you fail to timely notify SMHCS of a dependent's loss of eligibility; in these events, coverage may be terminated retroactively without advance notice.

EXTENSION OF COVERAGE PROVISIONS

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

Family and Medical Leave Act (FMLA)

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA, SMHCS will continue to maintain your Medical Benefits and Health FSA Benefits on the same terms and conditions as if you were still active, as described in this section.

If you are on a paid leave, SMHCS will require you to continue all Medical Benefits and Health FSA Benefits coverage while you are on paid leave SMHCS will continue to pay its share of the contributions, and you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis).

If you are going on unpaid FMLA leave, SMHCS will continue your Medical Benefits and Health FSA Benefits while you are on leave as follows:

Medical Coverage. SMHCS will continue to pay its share of the contributions. You will also pay your share of the contributions. You may elect to pay your share of the contributions during the leave with after-tax dollars, by sending bi-weekly payments to SMHCS by the due dates established by SMHCS. Should you fail to remit after-tax payments during the FMLA leave sufficient to cover your share of the contributions, coverage will continue, but payment of claims will be suspended until the date for which premium payment has been received in full. Upon return from leave, any unpaid balance will be withheld from compensation and coverage will continue without interruption. If you do not return from leave, coverage will terminate as of the last date for which payment was received, and you may elect to continue coverage under COBRA.

Health FSA. If you go on a qualifying leave under the FMLA, your coverage under the Health FSA will continue unchanged throughout the duration of the FMLA leave. No Contributions will be due or accepted during the duration of the leave. Upon return from FMLA leave, the Contribution amount applicable to the leave period will be added to the amount due for the remainder of the Plan Year, and your bi-weekly Contribution amounts will be adjusted accordingly.

Other benefits. If you are commencing or returning from FMLA leave, then your election for non-health benefits (such as Dependent Care FSA Benefits) will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave.

Coverage for Physically or Mentally Disabled Dependent Children

A child who is physically or mentally disabled may qualify for coverage beyond the age when other dependent coverage would end. For the dependent child to qualify, the Plan Sponsor must be notified within thirty-one (31) days after the date dependent coverage would normally end. The Plan Sponsor will require proof that the child:

1. Is mentally or physically disabled;
2. Is incapable of self-support and is chiefly dependent on the Covered Employee for support; and
3. Was a Covered Dependent under an SMH health plan on the day immediately prior to the attainment of such age.

In the case of a newly eligible Employee and/or Dependent, the Employee may cover a mentally or physically disabled child as long as the child was disabled prior to the age at which the child could no longer be covered under Family Coverage as a Dependent child under the Plan.

The coverage will continue as long as annual proof of the above requirements is submitted, the Covered Employee maintains dependent coverage and this Plan remains in full force and effect.

Extension During Non-FMLA Absence from Work

Medical Coverage. If an Employee ceases regular service due to an Employer-approved non-FMLA leave of absence, the Employee's coverage for himself and his Dependents will continue during the leave period so long as the Employee pays the *required contribution for* coverage as specified in the Employer's leave of absence policy. If the Covered Employee fails to make the required contribution for coverage to continue during the leave, coverage will be suspended until such time as payment is received. Upon return from leave, any unpaid balance will be withheld from compensation and coverage will continue without interruption. If the Covered Employee does not return from leave, coverage will terminate as of the last date for which payment was received, and the Employee may elect to continue coverage under COBRA.

***Flexible Spending Accounts*.** If you go on an unpaid leave of absence that does not affect eligibility, your coverage under the flexible spending accounts will continue unchanged throughout the duration of the leave. No contributions will be due or accepted during the duration of the leave. Upon returning from the leave, the contribution amount applicable to the leave period will be added to the amount due for the remainder of the Plan Year, and your bi-weekly contribution amounts will be adjusted. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Sarasota Memorial Health Care System's Medical Benefits Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Sponsor is Sarasota Memorial Health Care System, 1700 South Tamiami Trail, Sarasota, FL 34239. COBRA continuation coverage for the Plan is administered by WEBTPA, 8500 Freeport Parkway, Suite 400, Irving, TX 75063, 469-417-1782 or 800-758-2525. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, covered Retiree, the Spouse of a covered Employee, the spouse of a covered Retiree, or a Dependent child of a covered Employee or covered Retiree. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "Covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals,

independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee or Retiree.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce of a covered Employee or Retiree from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce.

(4) A covered Employee's or covered Retiree’s enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee or covered Retiree, or the covered Spouse or a Dependent child of the covered Employee or covered Retiree, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are

present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you may lose the right to convert to an individual health insurance policy.. Second, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family 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," even if that plan generally doesn't accept late enrollees. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the COBRA Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage, for months beginning after February 12, 2011 and before January 1, 2014. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Sponsor of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Sponsor or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the COBRA Administrator) will notify the COBRA Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Sponsor or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Sponsor or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:
Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Sarasota Memorial Health Care System
1700 South Tamiami Trail
Sarasota, Florida 34239

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce**, your notice must include **a copy of the divorce decree.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the COBRA Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects

COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan.

(5) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any Qualifying Event other than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The COBRA Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the COBRA Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

What special rules apply to the Health FSA? COBRA coverage for the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year.

COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by the reimbursable claims submitted up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year. Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Sponsor. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, 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.

Keep Your Plan Administrator Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Sponsor informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Sponsor.

HIPAA PRIVACY INFORMATION

Compliance with HIPAA Privacy Standards

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Effective September 23, 2013, under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Individual requests to further restrict uses or disclosures of protected health information will be considered and granted on a case-by-case basis. No grant of an additional restriction is final without it being in writing. In general, request for additional restrictions are more likely to be approved in relation to Protected Health Information generated from services paid exclusively outside the Plan.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(v) Notification to affected individuals, HHS, and the media (when required) if the Plan or one of its business associates discovers a breach of unsecured Protected Health Information. Individuals who want to be notified of breaches that are not otherwise required by law may request to be so notified.

(4) **Certification of Employer.** The Employer certifies to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan Documents or as required by law;

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

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

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder, or required by law;

(e) Make available Protected Health Information to individual Plan Members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan Members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan Members in accordance with Section 164.528 of the Privacy Standards;

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

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of 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 unfeasible;

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards;

(k) Not allow uses and disclosures of psychotherapy notes without an individual's authorization;

(l) Not allow disclosures of Protected Health Information for marketing purposes, or any disclosures that constitute a sale of Protected Health Information without an individual's authorization;

(m) Not use or allow the Plan to use genetic information for underwriting purposes; and

(n) Provide an individual with access to the electronic information in the electronic form and format requested by the individual, if it is readily producible, or, if not, in a readable electronic form and format as agreed to by the covered entity and the individual.

Please refer to SMHCS policies referring HIPAA privacy for information on the personnel authorized to access Protected Health Information.

Compliance with HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

RECOVERY RIGHTS

The Plan has a right to recover, by way of subrogation or right of reimbursement, any expenses paid on your or your dependents' behalf for which another policy or individual is legally responsible. 'You' includes any person receiving benefits under the Plan including all dependents.

The Plan has the right to recover any payments you receive from any third party's liability, including but not limited to any person alleged to have caused you to suffer injuries or damages, or other insurance covering the third party, as well any first party coverage including but not limited to any payments you receive from your own personal injury protection (PIP), med-pay, uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, or school insurance, workers compensation insurance or whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions. The benefits under this plan are secondary to any coverage or any other applicable insurance.

You agree as follows:

- To assign to the Plan all rights of recovery against third parties, to the extent of the reasonable value of services and benefits provided, plus reasonable costs of collection.
- To cooperate with the Plan in protecting its legal rights to subrogation and reimbursement.
- That the Plan's rights will be considered as the first priority claim against third parties, to be paid before any other of your claims are paid.
- That you will do nothing to prejudice the Plan's rights under this provision, either before or after the need for services or benefits under the plan.
- That the Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name.
- That regardless of whether or not you have been fully compensated and regardless of whether the payments you receive make you whole the Plan may collect from the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided under the plan.
- To hold in trust for the Plan's benefit under these subrogation provisions, any proceeds of settlement or judgment.
- That the Plan shall be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you.
- That you will not accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval.
- To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as the Plan may reasonably request from you.
- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan
  1. If the amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
  2. You fail to cooperate.

- In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portions of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your

obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.

- The Plan will not pay fees, costs, or expenses you incur with any claim or lawsuit, without our prior written consent. The ''common fund'' doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

The Plan will not pay fees, costs, or expenses you incur with any claim or lawsuit, without our prior written consent.

TERMINATION OF THE PLAN

The Employer shall have the right, at any time, to terminate, amend, or merge this Plan. The Employer makes no promise to continue these benefits in the future and the right to future benefits will never vest.

Upon termination, the rights of the Covered Persons to benefits are limited to claims incurred and due up to the date of termination.

RIGHTS OF COVERED EMPLOYEES

Non-Discrimination
In connection with the administration of this Plan, the Plan Sponsor or representatives of the Plan Sponsor will not discriminate unfairly between individuals in comparison to similar situations at the time of such action.

Choice of Service
The persons covered under this Plan have the sole right to select their own providers of health care. The Plan will not choose a provider for any Covered Person, or have any liability for any acts, omissions, or conduct of any provider.

The Plan's only obligation is to make payments according to the terms of the Plan. The payments which the Plan makes are not an attempt to fix the value of any services or supplies provided to a Participant.

Assignment of Benefits
A Participant will have the right to assign the payment of any benefits for which he is eligible to any eligible provider of services. If a provider makes a representation to the Third Party Administrator that a covered person under this Plan has made an assignment of benefit payments to the provider, the Third Party Administrator will make payment to the provider based on that representation.

Summary Plan Description
Participants are entitled to receive a copy of the Summary Plan Description containing details of Plan benefits and the amount of coverage provided. Covered employees who do not have a Summary Plan Description should contact their Human Resources Department or the Plan Sponsor for a copy.

INSTRUCTIONS FOR SUBMITTING MEDICAL CLAIMS

Customarily, claims will be submitted by the provider of care. In the rare instance that you submit the claim, be sure the bills submitted include all of the following:

1. Employee's name, health plan Member ID, and home address
2. If claim is made for a dependent, name and age
3. Employer's name and group number
4. Name and address of the Physician or Hospital
5. Physician's diagnosis
6. Itemization of charges
7. Date the Injury or illness began

These items are REQUIRED in order to accurately pay claims. Certain claims may require additional information before being processed.

All payments will be issued directly to the provider of the service unless receipted bills showing payment has been made are submitted. In the event of the Covered Person's death, direct payment will continue to be made to the provider.

Please direct all claims and any questions regarding claims to:

WEBTPA
PO Box 99906
Grapevine, TX 76099-9706

Inside the Sarasota Area: (941) 917-7991
Outside the Sarasota Area: (877) 697-2299

Every attempt will be made to help Covered Persons understand their benefits; however, any statement made by an employee of the Third Party Administrator or the Employee will be deemed a representation and not a warranty. Actual benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing. All benefit payments are governed by the provisions of the Summary Plan Description.

If a definite answer to a specific question is required, please submit a written request, including all pertinent information, and a statement from the attending Physician (if applicable), and a written reply (which will be kept on file) will be sent.

Time Limit for Submitting Claims
All claims must be submitted within 1 year from the date charges are incurred to be considered eligible for payment. A charge will be deemed incurred on the date services are actually rendered or supplies are actually received.

If it was not reasonably possible to submit the claim in the time required, the claim will not be reduced or denied solely for this reason, if the claim is submitted as soon as reasonably possible. The claim must be submitted no later than one year from the date of loss unless the Covered Person was legally incapacitated.

Right to Investigate Claims
The Plan Sponsor acting on its behalf retains the right to request any medical information from any provider of service it deems necessary to properly process a claim.

A Physician designated by the Plan Sponsor will have the right and opportunity to examine, at its expense, any person whose illness or Injury is the basis of any claim, when and as often as reasonably required and, in the event of death, to make an autopsy, unless prohibited by law.

DENIED MEDICAL CLAIMS APPEAL PROCESS

Pre-authorization Denial Appeal Process

Covered Persons are responsible for ensuring that specified services are pre-authorized by WEBTPA. When a Provider or Covered Person requests pre- authorized for a service, it is either approved or denied. Pre- authorized for a service may be denied due to:

- Not medically necessary;
- Not a covered benefit.
- Services not provided by an in-network provider or at an approved Facility

Written notification of the denial for pre- authorized for a requested service will be sent to the medical provider requesting the service. If a request for pre- authorized is denied, in whole or in part, the Covered Person or Provider may appeal the denial by making a written request for review within 180 days after the denial is received. A Covered Person has the right to:

- Review the Summary Plan Description and other papers affecting the denial;
- Argue against the denial in writing; and
- Have a representative act on behalf of the Covered Person in the appeal.

The decision on review shall be in writing and shall be made within 15 days of the receipt of the request for review. If your claim is urgent, you may request an expedited review. In that case, a decision will be made within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision.

If the pre- authorized is denied upon review the decision must include the following:

- The specific reasons for denial;
- The decision must be written in a manner understandable to the Covered Person; and
- The written denial will contain reference to the pertinent Plan provisions or medical protocols upon which the decision was based.

Appeals due to the denial of a pre- authorized should be addressed in writing to:

Sarasota Memorial Hospital
Attn: Gulf Coast Medical Management Medical Review
1700 S. Tamiami Trail
Sarasota, FL 34239

Correspondence should include:

- Primary insured's name and health plan Member ID;
- Patient's name and relationship to primary insured;
- Provider's name;
- Any additional information Participant feels would assist in reconsideration;
- Contact information, including daytime telephone number.

Post-Service Claim Denial and Claim Denial Appeal Process

1. Level One Appeal

In the event a claim is denied, the Covered Person will be advised of the following:

- The reason for the denial;
- Specific reference to Plan provisions on which the denial was based;
- Any additional material or information needed for further review of the claim;
- An explanation of the review procedure.

If a claim is denied, in whole or in part, the Covered Person may appeal the denial by making a written request for review within 180 days after the denial is received. A Covered Person has the right to:

- Review the Summary Plan Description and other papers affecting the claim;
- Argue against the denial in writing; and
- Have a representative act on behalf of the Covered Person in the appeal.

The decision on review shall be in writing and shall be made within 30 days of the receipt of the request for review. Claim denial Level One appeal requests should be addressed in writing to:

WEBTPA
Attn: Appeal Department
PO Box 99906
Grapevine, TX 76099-9706

Correspondence should include:

- Primary insured's name and health plan Member ID;
- Patient's name and relationship to primary insured;
- Provider's name;
- Any additional information Participant feels would assist in reconsideration;
- Contact information, including daytime telephone number.

If the claim is denied upon review, the decision must include the following:

- The specific reason or reasons for the adverse determination
- Reference to the specific Plan provisions on which the determination was based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.
- If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

2. Level Two Appeal

The Covered Person may appeal directly in writing to the Plan Sponsor for a Level Two review within 60 days after a claim denial has been reviewed and upheld by the Third Party Administrator. Claim denial Level Two appeal requests to the Plan Sponsor should be addressed in writing to:

Sarasota Memorial Health Care System
Attn: Benefits Department
1852 Hillview Street
Sarasota, FL 34239

Correspondence should include:

- Primary insured's name and health plan Member ID;
- Patient's name and relationship to primary insured;

- Provider's name;
- Any additional information Participant feels would assist in reconsideration;
- Contact information, including daytime telephone number.

The claims information provided will be submitted without any identifying data to a committee appointed by the Plan Sponsor. A written response to the Employee and/or Covered Person will be provided within 30 days of the receipt of the written claims appeal.

3. Level Three Appeal

If a claim is denied, in whole or in part, the Covered Person may appeal for a final external review with an Independent Review Organization within four months after the date of receipt of a notice of a denial under the Level Two appeal. Claim denial Level Three appeal requests should be addressed in writing to:

WEBTPA
Attn: Appeals Department--Level Three Appeal
PO Box 99906
Grapevine, TX 76099-9706

Correspondence should include:

- Primary insured's name and health plan Member ID;
- Patient's name and relationship to primary insured;
- Provider's name;
- Any additional information Participant feels would assist in reconsideration;
- Contact information, including daytime telephone number.

Within five business days following the date of receipt of the Level Three appeal request, **WEBTPA** will complete a preliminary review of the request to determine whether the claimant is eligible for the Level Three appeal. Within one business day after completion of the preliminary review, the Plan Sponsor will notify the Covered Person whether the claim is eligible for review or if more information is needed to make the request complete. The Covered Person will have up to the end of the initial four month period or within the 48 hour period following the receipt of the notification, whichever is later, to send any additional information requested.

The Plan Sponsor will assign an accredited independent review organization (IRO) to conduct the external review. The IRO will provide written notice of the final external review decision within 45 days after receipt of the request for external review to the claimant and the Plan Sponsor. Upon receipt of a notice of a final external review decision reversing the second level appeal, the Plan Sponsor will immediately provide coverage or payment for the claim.

Expedited External Review. The Plan will allow a Covered Person to request an expedited Level Three appeal if the denial of an appeal involves a medical condition for which the timeframe for completion of a Level Two or Level Three appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or if the second level adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

If it is determined that the claim is eligible for review, the IRO will provide notice of the final external review decision as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

DENIED PHARMACY CLAIMS APPEAL PROCESS

Pre-authorization Denial Appeal Process

Covered Persons are responsible for ensuring that specified prescriptions are pre-authorized through Navitus Health Solutions, LLC.. When a Provider or Covered Person requests pre-authorization for a prescription, it is either approved or denied. Pre-authorization for a prescription may be denied due to:

- Not medically necessary
- Not a covered drug
- Drug not approved for the diagnosis provided

Written notification of the denial for pre-authorization for a requested drug will be sent to the Provider requesting the prescription by Navitus. If a request for pre-authorization is denied, the Covered Person or Provider may appeal the denial by making a written request for review within 180 days after the denial is received. A Covered Person has the right to:

- Review the Summary Plan Description and other papers affecting the denial;
- Argue against the denial in writing; and
- Have the prescribing MD or Member act on behalf of the Covered Person in the appeal.

The decision on review shall be in writing and shall be made within 15 days of the receipt of the request for review. If your claim is urgent, you may request an expedited review. In that case, a decision will be made within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision.

If the pre-authorization is denied upon review the decision must include the following:

- The specific reasons for denial;
- The decision must be written in a manner understandable to the Covered Person; and
- The written denial will contain reference to the pertinent Plan provisions or medical protocols upon which the decision was based.

Appeals due to the denial of a pre-authorization should be addressed in writing and mailed or faxed to:

Sarasota Memorial Hospital
Attn: Pharmacy Case Manager
1700 S. Tamiami Trail
Sarasota, FL 34239
FAX: 941-917-2669

Correspondence should include:

- Primary insured's name and health plan Member ID;
- Patient's name and relationship to primary insured;
- Provider's name;
- Any additional information Participant feels would assist in reconsideration;
- Contact information, including daytime telephone number.

Prescription Claim Denial and Claim Denial Appeal Process

1. Level One Appeal

In the event a prescription is denied, the Covered Person will be advised of the following:

- The reason for the denial;
- Specific reference to Plan provisions on which the denial was based;
- Any additional material or information needed for further review of the claim;
- An explanation of the review procedure.

If a prescription is denied, the Covered Person may appeal the denial by making a written request for review within 180 days after the denial is received. A Covered Person has the right to:

- Review the Summary Plan Description and other papers affecting the claim;
- Argue against the denial in writing; and
- Have a representative act on behalf of the Covered Person in the appeal.

The decision on review shall be in writing and shall be made within 30 days of the receipt of the request for review. Claim denial Level One appeal requests should be addressed in writing and mailed or faxed to:

Sarasota Memorial Hospital
Attn: Pharmacy Case Manager
1700 S. Tamiami Trail
Sarasota, FL 34239
Fax: 941-917-2669

Correspondence should include:

- Primary insured's name and health plan Member ID;
- Patient's name and relationship to primary insured;
- Provider's name;
- Any additional information Participant feels would assist in reconsideration;
- Contact information, including daytime telephone number.

If the claim is denied upon review, the decision must include the following:

- The specific reason or reasons for the adverse determination
- Reference to the specific Plan provisions on which the determination was based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.
- If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

2. Level Two Appeal

The Covered Person may appeal directly in writing to the Plan Sponsor for a Level Two review within 60 days after a claim denial has been reviewed and upheld by the Pharmacy Case Manager. Prescription denial Level Two appeal requests to the Plan Sponsor should be addressed in writing to:

Sarasota Memorial Health Care System
Attn: Benefits Department
1852 Hillview Street, Ste. 203
Sarasota, FL 34239

Correspondence should include:

- Primary insured's name and health plan Member ID;
- Patient's name and relationship to primary insured;
- Provider's name;
- Any additional information Participant feels would assist in reconsideration;
- Contact information, including daytime telephone number.

The claims information provided will be submitted without any identifying data to a committee appointed by the Plan Sponsor. A written response to the Employee and/or Covered Person will be provided within 30 days of the receipt of the written claims appeal.

3. Level Three Appeal

If a prescription is denied, the Covered Person may appeal for a final external review with an Independent Review Organization (IRO) within four months after the date of receipt of a notice of a denial under the Level two appeal. Claim denial Level Three appeal requests should be addressed in writing to:

Sarasota Memorial Health Care System
Attn: Benefits Department – 3rd level appeal
1852 Hillview Street, Ste. 203
Sarasota, FL 34239

Correspondence should include:

- Primary insured's name and health plan Member ID;
- Patient's name and relationship to primary insured;
- Provider's name;
- Any additional information Participant feels would assist in reconsideration;
- Contact information, including daytime telephone number.

Within five business days following the date of receipt of the Level Three appeal request, the Plan Sponsor will complete a preliminary review of the request to determine whether the claimant is eligible for the Level Three appeal. Within one business day after completion of the preliminary review, the Plan Sponsor will notify the Covered Person whether the claim is eligible for review or if more information is needed to make the request complete. The Covered Person will have up to the end of the initial four month period or within the 48 hour period following the receipt of the notification, whichever is later, to send any additional information requested.

The Plan Sponsor will assign an accredited independent review organization (IRO) to conduct the external review. The IRO will provide written notice of the final external review decision within 45 days after receipt of the request for external review to the Covered Person and the Plan Sponsor. Upon receipt of a notice of a final external review decision reversing the Level Two appeal, the Plan will immediately provide coverage or payment for the claim.

Expedited External Review. The Plan will allow a Covered Person to request an expedited Level Three appeal if the denial of an appeal involves a medical condition for which the timeframe for completion of a Level Two or Level Three appeal would seriously jeopardize the life or health of the claimant or would jeopardize the Covered Person's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or if the Level Two adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Covered Person received emergency services, but has not been discharged from a facility.

If it is determined that the claim is eligible for review, the IRO will provide notice of the final external review decision as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

DENIED FLEXIBLE SPENDING ACCOUNT CLAIMS APPEAL PROCESS

If a claim for reimbursement from the Health FSA or Dependent Care FSA is wholly or partially denied, a written request for reconsideration may be submitted to the Plan Administrator.

GENERAL INFORMATION

Plan Sponsor / Employer:	SMH Health Care, Inc.
Corporate Address:	1700 South Tamiami Trail Sarasota, FL 34239
Phone:	(941) 917-6177
Contract Administrator:	WEBTPA
Contract Administrator's Address:	8500 Freeport Parkway South, Suite 400 Irving, TX 75063
Phone:	(877) 697-2299

Contribution Determinations
The Plan Sponsor will, from time to time, evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed (if any) by each Employee.

Employee Obligations
The coverage(s) afforded to an Employee, retired Employee or Dependents are partially funded by the Employer. The Employee will be responsible for payment of the portion of the coverage not funded by the Employer. For active Employees, the Employer will deduct such costs on a regular basis from the Employee's wages or salary. Retired Employees are required to make regular payments to WEBTPA.

Employer Obligations
The Employer will make contributions to the Plan for a portion of the cost Health Care Coverage(s) of Employees and Dependents.

Employer contributions and those paid by the Employee will be used to provide the non-insured benefits under the Plan. Contributions for insured coverages or ancillary coverages, if any, will be paid directly to the provider of such coverage.

Plan Funded Benefits
The contributions will be applied to provide the benefits under the Plan.

Insurance Policy(ies)
Contributions may be used to purchase insurance coverages to ensure that the Plan will meet its self-funded Health Care Coverage obligations. The policy(ies) may be reviewed upon request submitted to the Plan Sponsor. The Plan Sponsor is also available to answer any questions about the coverages. The provisions of this Summary Plan Description and Plan Document in no way modify those of any insurance policy.

Administration Expenses
Contributions may also be used to pay: (1) administrative expenses of the Plan in accordance with the terms and conditions of any administration agreement between the Plan Sponsor and Contract Administrator(s) and (2) other reasonable operating expenses of the Plan.

ADMINISTRATIVE PROVISIONS

Administration
Certain benefits of the Plan are administered by the Third Party Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and the Third Party Administrator.

Alternative Care
In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any Provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Covered Person would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to administer the Plan thereafter in strict accordance with the provisions of the Plan Document.

Amendment or Termination of the Plan
The Plan Sponsor expects the Plan to be permanent, but since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any Participant or beneficiary:

- determine eligibility for benefits or to construe the terms of the Plan;
- alter or postpone the method of payment of any benefit;
- amend any provision of these administrative provisions; and
- terminate, suspend, withdraw, amend, or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he has become entitled under the Plan prior to the date of the modification or amendment.

NOTE: Any modification, amendment, or termination action will be done in writing, or by written amendment that is signed by at least one Fiduciary of the Plan.

Anticipation, Alienation, Sale or Transfer
Except for assignments to providers of service (see **Instructions for Submitting Claims** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities. engagements, or torts of, or claims against, any Employee, Covered Dependent, or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error
Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Conflict of Provisions

With regard to any contract of insurance or reinsurance which is or becomes a part of the Plan, if any provision of such contract has been omitted from or is in conflict with the provisions of the Summary Plan Description, the appropriate insurance or reinsurance contract wording shall prevail.

Entire Contract

The Summary Plan Description, any amendments, and the individual applications, if any, of Covered Persons will constitute the entire contract between the parties. The Plan does not constitute a contract of employment or in any way affect the rights of an Employer to discharge any Employee.

Facility of Payment

Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or, in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator, or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciary Responsibility, Authority, and Discretion

Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Summary Plan Description, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Fiduciaries may employ such agents, attorneys, accountants, investment advisors, or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to, provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant, or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, the Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant, or

other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

[Please refer to the **Rights of Covered Employees** section for additional information about Fiduciary obligations. No provision in this section shall be construed to discharge Fiduciaries from any of their obligations or deprive Covered Employees of any of their rights under the law].

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology will also include the feminine (and vice-versa), and any term in the singular will also include the plural (and vice-versa).

Illegality of Particular Provision
The illegality of any particular provision of the Summary Plan Description will not affect the other provisions, but the Summary Plan Description will be construed in all respects as if such invalid provision were omitted.

Indemnification
To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, wilful neglect, or wilful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions
No Covered Person may sue for payment of claim: (1) within 60 days after the date proof of claim is sent as required, or (2) more than the applicable statute of limitations from the time proof of claim is required. If any time for giving notice or proof of claim or beginning legal action is less than that permitted by the laws in effect where the Plan is delivered, the limit will be extended to the minimum period of time permitted.

Misstatement of Age
If the age of a Covered Person has been misstated in enrolling, and if the amount of the contribution required of an Employer with respect to such Covered Person is based on age, an adjustment of such contribution amount will be made based on the Covered Person's true age. Contributions so affected (including correction of prior miscalculated contributions) will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

If age is a factor in determining eligibility or the amount of a benefit, and there has been a misstatement of age of a Covered Person in enrolling or claims filing, his eligibility or amount of benefits, or both, will be adjusted in accordance with his true age. Upon the discovery of a Covered Person's misstatement of age, benefits affected by such misstatement will be adjusted immediately.

Any misstatement of age will neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force.

Misuse of Identification Card

If an Employee or Covered Person permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of 31 days from the date written notice is given.

Physical Examination and Autopsy

The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as may reasonably required during the pendency of any claim, and to make an autopsy in case of death, where it is not forbidden by law.

Privacy Statement

Sarasota Memorial Health Care System (SMHCS) is committed to safeguarding the confidential information of your nonpublic information. Because SMHCS respects the individual's right to privacy, a high priority has always been placed on the personal information you provide. All personal information provided to Sarasota Memorial Health Care System is held in the strictest confidence. Information is never disclosed to non-affiliated third parties, except as required by law, and there is no anticipation of doing so in the future. Health and financial information that you provide is used to meet your personal financial goals and to administer health benefits while guarding against any real or perceived infringements on your rights of privacy. SMHCS's policy with respect to personal information about you is listed below.

Employee and third party access to information is limited to only those who have a business or professional reason for access. For example, the minimum necessary information may be shared with insurance carriers and other third parties in order to obtain proposals on your behalf and to administer your health benefits.

A secure office and computer environment is maintained to ensure that your information is not placed at unreasonable risk. There are policies that provide for:

- Password protection on database access for employees and clients,
- Monitoring of our computer networks and testing of the strength of our security in order to help us ensure the safety of client information,
- Backup and recovery procedures.

The categories of nonpublic personal information that are collected from a third party depends on the scope of the third party engagement. It will include information about your health to the extent that it is needed for the underwriting process, information about your transactions between you and health care providers and other third parties, and information from consumer reporting agencies.

For unaffiliated third parties that require access to your personal information, including financial service companies, consultants, and other professionals, information is provided only with your approval and requires strict confidentiality in our agreements with them. Federal and state regulations may also review SMHCS's records as permitted under law.

Your personal identifying information is not provided to mailing list vendors or solicitors for any purpose, at any time, under any circumstances.

Personally identifying information about you will be confidentially maintained during and after your employment with Sarasota Memorial Health Care System for the required time thereafter that such

records are required to be maintained by federal and state securities laws, the Internal Revenue Service, any applicable state department of insurance and consistent with sound business practices.

If you would like to discuss the confidentiality and privacy of your nonpublic personal information in detail, or if you ever have concerns, please feel free to contact the Human Resources Department.

Reimbursements
Whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan Sponsor and the Third Party Administrator will be authorized to pay such benefits to the other party, provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Right of Recovery
Whenever any benefit payments have been made by the Plan in excess of the maximum amount required under the terms of the Summary Plan Description, the Plan will have the right to recover all such excess amounts from any persons, insurance companies, or other payees, and the Employee or Dependent will make a good faith attempt to assist the Third Party Administrator in such recovery.

The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services is covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services is not covered hereunder. The Covered Person (parent, if a minor) will execute and deliver to the Plan all assignments and other documents necessary or useful to the Plan Sponsor or Third Party Administrator for the purpose of enforcing the Plan's rights under this provision.

Rights Against the Plan Sponsor or Employer
Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Substitution
The Plan Sponsor will be substituted for all rights of an Employee to recover attorney fees against any adverse party. Employees will do nothing to prejudice such rights of the Plan Sponsor and further they agree to do all acts necessary to preserve and take advantage of such rights. If payment has been made by the Plan in such instances, and if the adverse party reimburses the Employee directly, the Plan will have the right to recover such payment from an Employee.

Titles or Headings
Where titles or headings precede explanatory text throughout the Summary Plan Description, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Summary Plan Description and will not affect the validity, construction, or effect of the Summary Plan Description provisions.

Workers' Compensation
The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation insurance laws or similar legislation.