PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND

PLAN DOCUMENT
REVISED AND RESTATED

AND SUMMARY PLAN DESCRIPTION

Effective: January 1, 2011
Palm Beach County Firefighters Employee Benefits Fund  
Plan Document, Revised and Restated and Summary Plan Description  
(Effective January 1, 2011) 

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MISCELLANEOUS INFORMATION

Claims Administrator for This Plan: UMR, INC.
333 West Vine Street, Suite 500
Lexington, KY 40507

Phone: (877) 210-1840 (Toll-Free)
(800) 651-8231 (Option #1)

(Group No. 0081691)

Consultant for This Plan: THE STEINER GROUP, INC.
8665 Cobblestone Point Circle
Boynton Beach, FL 33437-4431

Phone: (561) 799-2744

Fund Office for This Plan: 2328 S. Congress Avenue, Suite 2C
West Palm Beach, FL 33406

Phone: (561) 969-6663

Legal Counsel for This Plan: MIERZWA & ASSOCIATES, P.A.
3900 Woodlake Boulevard, Suite 212
Lake Worth, FL 33463-3045

Phone: (561) 966-1200

Agent for Service of Legal Process: Matthew J. Mierzwa, Jr., Esquire
MIERZWA & ASSOCIATES, P.A.
3900 Woodlake Boulevard, Suite 212
Lake Worth, FL 33463-3045

Federal Tax Identification Number for This Plan: 59-2477751

Plan Identification Number: 501
1. **PLAN DOCUMENT REVISED AND RESTATED AND SUMMARY PLAN DESCRIPTION**

This document, and the Trust Agreement, which you can read at the Fund Office, explain the benefits, rights and obligations you have under the health insurance plan established by the Board of Trustees of the Palm Beach County Firefighters Employee Benefits Fund pursuant to the collective bargaining agreement between Palm Beach County Fire Rescue and the Professional Firefighters/Paramedics of Palm Beach County, Local 2928, IAFF, Inc. The Plan Document Revised and Restated and Summary Plan Description (hereinafter “Plan Document”), as well as the Trust Agreement, shall govern if there are any discrepancies between the information in the aforementioned documents, and any other disseminated materials or information.

2. **QUESTIONS AND ANSWERS**

2.1 When is Notification required?

Notification is required for all in-patient hospital admissions and for all out-patient surgeries performed in an ambulatory surgery center, out-patient surgery center or hospital setting, skilled nursing facility, home-health care, durable medical equipment over $500 per month for rental or $1500 for purchase, prosthetics over $1000; organ and tissue transplants, inpatient behavioral health, mental health, substance abuse, and dialysis. An emergency non-scheduled in-patient hospital admission must be pre-certified within 48 business hours or two (2) business days of the admission.

2.2 What is meant by a PPO?

A Preferred Provider Organization (PPO) is a network of individual physicians and hospitals that discount fees in exchange for an anticipated increased volume in patients. The PPO used by the Fund is United Healthcare Choice-Plus (UHC). If you do not have access to a PPO Provider within 20 road miles of your home, covered expenses received from a non-PPO Provider shall be payable at the PPO benefit level provided you have sought notification from UMR (see Section 5).

2.3 Why should I use a Panel Provider?

Because Panel Providers have made agreements to reduce their fees, you and the Fund save money.

2.4 What if I have questions about my benefits or a claim payment?

Contact UMR, Inc. (UMR) at 1- (877)-210-1840. If you have a problem with the way your claim was paid after discussing it with UMR, you can call the Fund Office at (561) 969-6663.
3. **HOW TO FILE A CLAIM**

3.1 **MAILING ADDRESS:** Mail the claim form and itemized bill(s) to the address shown on the back of your ID card.

UMR, Inc.
P.O. Box 826
Onalaska, WI 54650-0826
Payor ID# 79480

3.2 **PROCEDURE FOR SUBMITTING A CLAIM:** If a claim has not been filed by your physician or hospital, you will be responsible for submitting the claim for payment. Please follow these guidelines:

a) Obtain the appropriate claim form from the Fund Office (or from IAFF2928.com or UMR.com ) and complete the “Employee’s Statement” in full. If any questions are not answered, it may be necessary to return the claim, which will delay payment.

b) Attach the itemized billing to the claim form. All bills **MUST** include the following:

1) Name, address, and tax identification number of the physician or hospital;
2) Insured’s name, employer name, social security number, and home address;
3) Patient’s name and date of birth;
4) Date of each service;
5) Description of each service rendered, including procedure codes, when applicable;
6) Amount charged for each service;
7) Physician’s diagnosis.

**DO NOT SUBMIT CANCELED CHECKS, CREDIT CARD RECEIPTS, OR CASH REGISTER RECEIPTS. THEY DO NOT CONTAIN THE INFORMATION NECESSARY TO PROCESS A CLAIM.**

c) Each Covered Person should submit a completed claim form every six months or when a claim is for the treatment of an accidental injury or an emergency illness. The claim form must contain the details of the accident or illness (how, where, and when). This will help expedite the processing of the claim.

3.3 **REFUNDS WITH RESPECT TO OVERCHARGES:** If a Covered Person discovers he or she was overcharged by a hospital, physician, clinical lab or other health care providers, the Covered Person shall receive a refund of 50% of any amount recovered as a result of such overcharge, up to a maximum payment of $1,000 per admission.
4. **PREFERRED PROVIDER ORGANIZATION (PPO)**

A PPO is a contractual agreement with a panel of hospitals and/or physicians whereby these service providers will discount their services in return for higher volume. The higher volume is expected by Plan design to reward its participants for using the more cost efficient and less expensive preferred provider for medical care.

With this in mind, this Plan was designed to encourage the use of preferred providers through United Healthcare Choice Plus Network UHC). If you or a Covered Dependent elect to use a Panel Provider (hospital and/or physician), there is no deductible and the Plan pays a higher percentage than if you were to use a non-panel provider. By contrast, if a non-panel provider is utilized, you will be obligated to meet a deductible and the Plan will pay a lower percentage of your bill.

Please remember that using a PPO helps to control the overall cost of insurance coverage, which has a direct relationship to the amount of payroll deductions for health insurance premiums.

If you have any questions about the PPO program, call UMR, Inc. (UMR), at 1-(877) 210-1840.

If you have any questions about the PPO panel, call United Healthcare., at 1-800-651-8231 (Option 1).

**Your provider may have once been part of the in-network PPO panel but is now an Non-PPO Panel provider. It is your responsibility to verify that the provider you selected is a United Healthcare Choice-Plus provider. This must be done by contacting United Healthcare.**
5. **NOTIFICATION REQUIREMENTS**

The *Utilization Management company (UM)* shown as the notification number on your ID card will handle the notice requirements of your plan. **If you plan on visiting a non-PPO panel provider**, you should call the UM as soon as possible to receive proper care coordination. However, you must call within the time frames shown below. The UM toll-free number is shown on the back of your ID card. Please reference the chart below for a quick summary of the notification requirements.

<table>
<thead>
<tr>
<th>NOTICE REQUIRED</th>
<th>NON-COMPLIANCE PENALTY</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital, skilled nursing facility, home-health care, durable medical equipment over $500 per month for rental or $1500 for purchase, prosthetics over $1000; organ and tissue transplants, inpatient behavioral health, mental health, substance abuse, and dialysis,</td>
<td>PPO panel: No penalty. Non-PPO panel: $100 per occurrence. The penalty is taken prior to applying the deductible and coinsurance provisions of the plan. The penalty is not applied to the out-of-pocket limit.</td>
<td>PPO panel: Your PPO provider is required to notify UM. Non-PPO panel: You must call UM at least five days in advance of any non-emergency inpatient admission. All inpatient admissions, except maternity admissions that do not exceed 48 hours for a normal vaginal delivery or 96 hours for a cesarean section delivery, require you to notify UM. If you do not notify UM, benefits will be payable after the non-compliance penalty. If admission is on an emergency basis, UM must be notified by the first business day following your admission.</td>
</tr>
<tr>
<td>Outpatient Surgery, skilled nursing facility, home-health care, durable medical equipment over $500 per month for rental or $1500 for purchase, prosthetics over $1000; organ and tissue transplants, inpatient behavioral health, mental health, substance abuse, and dialysis,</td>
<td>PPO panel: No Penalty Non-PPO panel: $100 per occurrence. The penalty is taken prior to applying the deductible and coinsurance provisions of the plan. The penalty is not applied to the out-of-pocket limit.</td>
<td>PPO panel: Your PPO provider is required to notify UM. Non-PPO panel: You must call UM at least five days in advance of any non-emergency outpatient surgery (when received at an ambulatory surgery center, outpatient surgery center or outpatient hospital department). If you do not notify UM, benefits will be payable after the non-compliance penalty. If your outpatient surgery is on an emergency basis, UM must be notified by the first business day following your admission.</td>
</tr>
</tbody>
</table>

If a Non-PPO Panel Network admission does not receive notification, a $100 penalty will be assessed in addition to any deductibles and other charges.

Notifications obtained for multiple visits for the same procedure will continue for one year from the authorization effective date. If continued care is needed after one year, a new notification must be obtained through UMR before authorization expiration notice.

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Palm Beach County Firefighters Employee Benefits Fund
Plan Document, Revised and Restated and Summary Plan Description
(Effective January 1, 2011)
NOTICE REQUIREMENTS - HOW THE PROGRAM WORKS
When you call UM, you will be asked the following questions:

1. Group name and number
2. Name of employee
3. Employee's Social Security #
4. Name of patient
5. Patient's birthday
6. Patient's address
7. Admitting facility and phone number, if applicable
8. Physician's name and phone number
9. Reason for admission or treatment
10. Admission or treatment date

Once notice is provided, it is valid for 30 days (excluding pregnancies) from the scheduled date of treatment. A new notice must be made if: you do not receive the treatment within 30 days of the scheduled date; you use a different facility or physician; or you are admitted for a different reason.

NOTICE REQUIREMENTS
You or your qualified practitioner are required to notify UM prior to receiving certain types of health care. The services that require prior notice are listed on the Schedule of Benefits. If you are required to provide prior notice and fail to do so, benefits may be reduced or denied.

NOTIFICATION DOES NOT GUARANTEE BENEFIT PAYMENT. BENEFITS ARE SUBJECT TO ALL PLAN PROVISIONS.

NON-COMPLIANCE PENALTY
If the provider is required to provide notice and it is not provided, you will not be subject to the non-compliance penalty. Your treatment will be reviewed when a claim is received.

If you are required to provide notice and it is not provided, your treatment will be reviewed when a claim is received. If it is determined to be a covered expense, benefits that are otherwise payable will be reduced as shown on the Schedule of Benefits under Non-Compliance Penalty. The penalty may be taken from any charges relating to the treatment. The penalty is taken before subtracting any deductible and coinsurance. The penalty is not applied to the out-of-pocket limit.

If your treatment is not a covered expense, no benefits will be payable under the Plan.

NOTICE SECONDARY COVERAGE WAIVER
If this Plan is secondary to another medical plan that also covers you, pre-certification will not be required.

CASE MANAGEMENT
Case management services help you use your benefits wisely during periods of treatment due to a serious sickness or injury. This is done through early identification of the need for case management in UM. Followed by on-going work with you and your provider to plan health care alternatives to meet your needs. The case manager will try to conserve your benefits by making sure that your care is handled as efficiently as possible.

The case management staff at UM consists of licensed, professional nurses. The nurses have years of experience in health care. They know the importance of not intruding in the doctor/patient relationship. By promoting health care alternatives that are acceptable to you, your doctors and your employer, case management helps to control health care costs and use your benefits wisely.
6. **ELIGIBILITY FOR PARTICIPATION**

6.1 **EMPLOYEES**

All employees of Palm Beach County Fire Rescue and employees of other municipal fire departments or districts that have a participation agreement with the Fund are eligible to participate in the Plan.

It is the Covered Employee’s responsibility to notify the Plan Administrator of any change in status that may affect their premium. Any failure to notify the Plan Administrator of a change in status which results in an overpayment of premiums to the Fund may only be recovered for a six month period from the date of the qualifying event, unless the error or omission is that of the Fund.

Coverage for an employee placed on administrative leave without pay shall continue for 30 days from notice to Fund Office or actual date, whichever is later. The employee shall be provided notice that coverage will be ending at that time. The employee shall then be eligible for Continuation Coverage after that date (refer to 19.1,F). Insurance benefits or premiums which are part of an arbitration award or pre-arbitration settlement shall be applied accordingly.

6.2 **DEPENDENTS**

A Covered Employee’s spouse and all children under twenty-six (26) years of age are eligible to participate in the Plan. The term “children” shall include natural children, legally adopted children, stepchildren, foster children, children under legal guardianship (subject to verification of court appointment of such guardianship or annual verification of claimed dependency status with respect to federal income tax), and children under long-term custody (subject to verification of court appointment of such long-term custody).

There shall be a one-time thirty (30) day special enrollment period beginning January 1, 2011 for participants to enroll children that meet the new eligibility requirements as noted above. Coverage requested under this one-time special enrollment shall be effective January 1, 2011.

The Covered Employee, at his or her option, may extend coverage to an eligible dependent child until the end of the calendar year in which the child reaches the age of 30 if the child:

1. is unmarried and does not have a dependent of his or her own; and
2. is a resident of the State of Florida or is a full-time or part-time student at an accredited college or university institution offering post-high school education; and
3. is not named a subscriber, insured, enrollee, or covered person under any other health insurance policy, or is entitled to benefits under Title XVIII of the Social Security Act (Medicare).

An eligible dependent child who was provided coverage under the Covered Employee’s policy after the end of the calendar year in which the eligible dependent child reaches age 26 whose coverage was subsequently terminated is not eligible for coverage under this section unless the eligible dependent child was continuously covered by other creditable coverage without a gap in coverage of more than 63 days.

Newborn children are eligible from birth, provided they are added to the Plan within thirty (30) days of birth. Failure to notify the Plan within thirty (30) days of birth may result in your being charged an additional premium.
Benefits applicable to children apply to adopted children from the moment of placement in the residence with no pre-existing condition exclusion, or for a newborn adoption coverage begins at the moment of birth, provided that the Fund is notified within thirty (30) days of the placement or birth. Failure to notify the Plan within thirty (30) days of birth may result in your being charged an additional premium.

A child who is physically or mentally incapable of self-sustaining employment upon attaining age twenty six (26) may be continued as an eligible dependent if chiefly dependent upon the Covered Employee for support and maintenance while remaining incapacitated, unmarried, and continuously covered under the Plan. To continue a child under this provision, proof of incapacity may be required from time to time.

The term "Dependent" shall not include anyone who is covered as an Eligible Employee, any child of a dependent child, except as outlined in section 11.8, c, 28, or any person who is in full-time military service.

If both parents are Covered Employees, a child may be included only as a dependent of one of the parents.

The surviving spouse and surviving dependents of the Covered Employee who were covered as of the date of death are eligible until remarriage of the surviving spouse, or until they are no longer dependents, whichever comes first, provided that a written election for continuation coverage is made. There will be no charge for the first three months of continuation coverage. Thereafter, the premium for continuation coverage shall be the retiree rate or the continuation coverage rate, whichever is less.

6.3 RETIREES

Any Employee who retires from Palm Beach County Fire Rescue or other municipal fire departments or districts that have a participation agreement with the Fund may elect to be covered by this Fund, effective on their date of termination from coverage as an Employee, provided the following conditions are met:

a) A written election to continue to participate is made and received by the Board within sixty (60) days of the effective date of termination from coverage as an employee. All applicable costs of coverage have been paid in full including back premiums to the date of termination from coverage as an employee; and

b) The Retiree must either

1) remain a Participant/Member in the Florida Retirement System (FRS), and either

   (a) have at least ten (10) years of service in the FRS before July 1, 2001, or have at least six (6) years of service in the FRS on or after July 1, 2001, or

   (b) be eligible to immediately receive disability benefits from FRS; or

2) have retired under the long term disability provisions of the collective bargaining agreement between Palm Beach County and the Professional Firefighters/Paramedics of Palm Beach County, Local 2928, International Association of Fire Fighters, Inc.; or

3) have retired under a pension plan that an Employee elected to remain in rather than transfer to the FRS upon being hired by Palm Beach County Fire Rescue as a result of a merger with another municipal fire department or district; or

4) have retired under a pension plan of other municipal fire departments or districts that have a participation agreement with the Fund; and

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c) The Retiree and/or his Covered Dependent(s) must obtain and maintain Medicare Part A and Part B coverage whenever they first become eligible for Medicare.

Retiree coverage may include dependents, as defined by the Plan, and will be subject to the provisions thereof.

The surviving spouse and surviving dependents of the Retiree who were covered as of the date of death are eligible until remarriage of the surviving spouse, or until they are no longer dependents, whichever comes first, provided that a written election for continuation coverage is made. There will be no charge for the first three months of continuation coverage. Thereafter, the premium for continuation coverage shall be the retiree rate or the continuation coverage rate, whichever is less.

6.4 OTHER EMPLOYEES

Employees of the Palm Beach County Firefighters Employee Benefits Fund and of the Professional Firefighters/Paramedics of Palm Beach County, Local 2928, IAFF, Inc., employed and scheduled to work 30 hours per week or more are eligible to participate in the Fund, on the same terms and conditions as employees of Palm Beach County Fire Rescue, after a 60 day waiting period. Employees covered under this section shall be eligible to receive an annual physical pursuant to the “Annual Adult Maintenance Guidelines” provided in this Plan Document.

Upon retirement, employees of the Palm Beach County Firefighters Employee Benefits Fund and of the Professional Firefighters/Paramedics of Palm Beach County, Local 2928, IAFF, Inc., may elect to be covered as retirees by this Fund, effective on their date of termination from coverage as an employee, provided the following conditions are met:

a) A written election to continue to participate is made and received by the Board within sixty (60) days of the effective date of termination from coverage as an employee. All applicable costs of coverage have been paid in full including back premiums to the date of termination from coverage as an employee; and

b) The Retiree shall:

1) complete at least six (6) years of service with the Palm Beach County Firefighters Employee Benefits Fund or the Professional Firefighters/Paramedics of Palm Beach County, Local 2928, IAFF, Inc.; and

2) obtain and maintain, as well as his/her covered dependent(s), Medicare Part A and Part B coverage whenever they first become eligible for Medicare.

Retiree coverage may include “dependents”, as defined by the Plan, and will be subject to the provisions thereof.

The surviving spouse and surviving dependents of the other employee who were covered as of the date of death are eligible until remarriage of the surviving spouse, or until they are no longer dependents, whichever comes first, provided that a written election for continuation coverage is made. There will be no charge for the first three months of continuation coverage. Thereafter, the premium for continuation coverage shall be the retiree rate or the continuation coverage rate, whichever is less.
7. **EFFECTIVE DATE OF COVERAGE**

7.1 **EMPLOYEE EFFECTIVE DATE**

Coverage for all newly hired Employees becomes effective the first day following thirty (30) calendar days of continuous employment provided the employee has completed the required Enrollment and Salary Deduction forms.

Coverage for Employees hired by Palm Beach County Fire Rescue as a result of a merger with another municipal fire department or district becomes effective on the date of the merger, provided the employee has completed the required Enrollment and Salary Deduction Form. However, said coverage for newly hired or merging Employees shall be subject to application of the Pre-Existing Condition provision contained in the Plan Document.

“Active Work” and “Actively at Work” means the actual expenditure of time and energy by the Employee, performing each of the main duties of his/her regular job on a full-time basis in the place where and the manner in which such job is normally performed. If the Employee was actively at work, as defined above, on his/her last regular working date then he/she shall be deemed to be actively at work on each day of paid vacation or paid status or regular non-working day on which he/she is not disabled.

7.2 **DEPENDENT EFFECTIVE DATE**

Coverage for Dependents of newly hired Employees shall become effective on the first day following thirty (30) calendar days of continuous employment by the newly hired employee, subject to the rules below provided a completed enrollment and salary deduction form is received by the Fund within thirty (30) days from the date of hire.

Coverage for Dependents of Employees hired by Palm Beach County Fire Rescue as a result of a merger with another municipal fire department or district shall become effective on the date of the merger, subject to the rules below. Coverage for Dependents who were previously covered under the Plan shall become effective upon receipt by the Fund office of the Employee’s completed enrollment card and payroll deduction authorization forms. Dependent coverage, except for those under the age of 19, is subject to application of the Pre-Existing Condition provision contained in the Plan Document. If the completed enrollment and payroll deduction authorization form(s) for Dependent(s) are not received by the Fund office within thirty (30) days from the date of hire, the dependent will be treated as a “Late Enrollee” as defined by the Plan and will be subject to the provisions thereof.

If a Dependent, other than a newborn child or children, is hospital confined or disabled on account of injury or sickness on the date of his/her coverage or any change in coverage should otherwise take effect, it shall take effect on the date the disability ends.

Coverage for dependents will not become effective before the Employee’s coverage becomes effective.

The coverage of a newborn dependent child shall take effect on the date of birth of such child whether or not such child is hospital confined or disabled; however, in order for the expense of the delivery of a newborn dependent to be considered Eligible, the Employee must have made all necessary arrangements to have effectuated family coverage, retroactive to the beginning of the month of delivery, within thirty (30) days following the date of delivery. Further, such Eligible Expense shall include the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity.
7.3 **OPEN ENROLLMENT**

The Palm Beach County Firefighters Employee Benefits Fund will conduct an open enrollment period to allow employees of Palm Beach County Fire Rescue, the Palm Beach County Firefighters Employee Benefits Fund, the Professional Firefighters/Paramedics of Palm Beach County, Local 2928, IAFF, Inc., other municipal fire departments or districts that have participation agreements with the Fund, and their Dependents to participate in the Plan. The Fund will announce the enrollment period prior to October of each year. The period will last 30 days and may be extended due to holidays or other circumstances, to be no longer than 45 days. Coverage resulting from open enrollment shall become effective the following January 1.

7.4 **SPECIAL ENROLLEE**

A special enrollee is defined as:

a) a person who becomes an eligible dependent through marriage, birth, adoption, or placement for adoption; or

b) an Eligible Employee or dependent who loses other health coverage provided that:

1) the person was covered under a group health plan or had insurance coverage as an employee or dependent at the time they were initially eligible to enroll for coverage under the Plan; and

2) when coverage was offered under this Plan at the time of initial eligibility, the person stated in writing that coverage under another group health plan or health insurance coverage was the reason for declining enrollment; and

3) the person demonstrates that he or she has lost coverage within the past 30 days as a result of exhausting COBRA continuation coverage, or legal separation, divorce, death, termination of employment, or a reduction in hours of employment, or the termination of the other coverage as a result of the termination of employer contributions; or

c) an employee and eligible dependents, if the employee was covered under the Plan but dropped such coverage to be covered as a dependent under a spouse’s employer-sponsored group health plan and subsequently demonstrates a loss of such coverage because of the termination or reduction of hours in the spouse’s employment.

d) an employee with single health coverage and an employee-spouse with single health coverage who become eligible for family coverage upon the birth or adoption of a child.

A request for special enrollment must be made within 30 days of the marriage, birth, adoption or placement for adoption, or of losing other health coverage. When coverage is requested as stated above, enrollment will be allowed outside of the initial enrollment or annual open enrollment period. Coverage under (b), (c) and (d) will become effective upon receipt by the Fund Office of the Employee’s completed enrollment card and payroll deduction authorization forms. Dependent coverage for marriage shall begin on the date of marriage; or on the date of a dependent’s birth or adoption. If enrollment is not completed as previously stated, that person will be considered as a “Late Enrollee.” The pre-existing conditions exclusion may apply up to twelve (12) months except for dependents under the age of 19.
7.5 LATE ENROLLEE

A late enrollee is defined as a person who does not enroll in the Plan at the time when the person is first eligible to enroll or during a special enrollment period for a person considered to be a “Special Enrollee.” A person considered to be a late enrollee will not be allowed to enroll in the Plan outside of the initial enrollment or annual open enrollment period. The effective date of a late enrollee’s coverage will be delayed until the next annual open enrollment period and the preexisting conditions exclusion may apply up to eighteen (18) months except for dependents under the age of 19.

8. EFFECTIVE DATE OF TERMINATION FROM COVERAGE

8.1 EMPLOYEES

An Employee's coverage will be terminated concurrent with the date his employment terminates, except as required by law, or on the date the required payroll deductions are not made. Coverage for an employee placed on administrative leave without pay shall continue for 30 days from such occurrence. The employee shall be provided notice that coverage will be ending at that time. The employee shall then be eligible for Continuation Coverage after that date. Insurance benefits or premiums which are part of an arbitration award or pre-arbitration settlement shall be applied accordingly.

8.2 DEPENDENTS

In the event an Employee's coverage is terminated, and their Dependents were covered under the Plan at the time, then coverage for all Dependents will terminate concurrent with coverage for the Employee. However, any payroll deductions paid to the Plan for any period after the date of termination, applicable to coverage subsequent to the actual date of termination, shall be refunded to the Employee.

In the event payroll deductions are not paid to the Plan in full for an entire calendar month, then coverage for Dependents may be terminated effective the last day of the month for which payroll deductions were paid to the Plan in full for an entire calendar month. If coverage is terminated, any payroll deductions paid to the Plan for any period after the date of termination, applicable to coverage subsequent to the actual date of termination, shall be refunded to the Employee provided no claim payments were made for services rendered subsequent to the actual date of termination of any, and all, dependents. In the event claims were paid, the amount to be refunded shall be reduced by the amount of all such payments.

8.3 INDIVIDUAL TERMINATIONS

The coverage of the Covered Person shall terminate: (1) on the date the Covered Person ceases to be eligible for coverage according to the Rules of Eligibility; (2) on the date the Covered Person, if a dependent, ceases to be a dependent as defined herein; (3) on the date that the Covered Person fails to make any necessary self-contribution salary reduction as required under the Rules of Eligibility; and (4) on the first day of the month following that month an Employee's coverage is terminated according to the Rules of Eligibility due to his/her death.

8.4 FRAUDULENT CLAIMS

Coverage may be terminated for the submission of a fraudulent claim (refer to section 16 for additional information).
9. **DEFINITIONS**

9.1 **ACCIDENTAL INJURY**

“Accidental Injury” means an injury sustained as the result of accidental external violent circumstances such as the impact of a moving body, vehicle collision, or fall.

9.2 **AMBULATORY SURGICAL CENTER**

An “Ambulatory Surgical Center” means a lawfully operating facility which is primarily engaged in providing elective surgical care for which a patient is admitted and discharged within the same day.

9.3 **AMENDMENT**

"Amendment" means a formal document that changes the provisions of the Plan Document duly signed by the Board of Trustees of the Palm Beach County Firefighters Employee Benefits Fund.

9.4 **CHILDREN**

Children shall include natural children, legally adopted children, stepchildren, foster children, and children under legal guardianship (subject to verification of court appointment of such guardianship and annual verification of claimed dependency status with respect to federal income tax).

9.5 **CLAIMS ADMINISTRATOR**

Claims for benefits are administered by a professional third party claims administrator, UMR, Inc. (UMR).

9.6 **COVERED PERSON**

“Covered Person” means a person who is eligible and properly enrolled in the Plan.

9.7 **CUSTODIAL CARE**

"Custodial care" means that type of care or service wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which normally can be self-administered.

9.8 **DURABLE MEDICAL EQUIPMENT**

"Durable medical equipment" means equipment which is:

- a) Able to withstand repeated use;
- b) Primarily and customarily used to serve a medical purpose; and
- c) Not generally useful to a person in the absence of illness or injury.
9.9 DURING ANY DISABILITY

“During any disability” means all disability and complications from the same cause until (1) a Covered Employee recovers or returns to active full-time employment, or (2) for a Covered Dependent until he recovers and resumes normal activities for a period of three (3) months.

9.10 EFFECTIVE DATE

The effective date of the Plan is November 1, 1984, amended, revised, and restated effective January 1, 2011.

9.11 ELECTIVE SURGICAL PROCEDURE/ELECTIVE SURGERY

“Elective Surgical Procedure/Elective Surgery” means a non-emergency surgical procedure which is scheduled at the employee's convenience without endangering the employee's life or without causing serious impairment to the employee's bodily functions.

9.12 EMERGENCY

“Emergency” illness or injury means an unexpected serious happening, demanding immediate attention including but not limited to the following: asphyxiation, bites or stings, choking, convulsion, dislocation, drowning, fainting, fire emergencies, foreign bodies, poisoning, shock, unconsciousness, and severe bleeding.

9.13 EXPENSE INCURRED

“Expense incurred” means only fees charged for necessary medical services and supplies which are regularly and customarily charged for such services and supplies generally furnished for cases of comparable nature and severity in the particular geographical area concerned. Expense is considered to be incurred on the date the service or supply is rendered or obtained, not on the date of the bill.

9.14 FULL-TIME EMPLOYMENT

"Full-time Employment” means a normal work week of thirty (30) or more hours.

9.15 FUND

The proper name of the Fund is the Palm Beach County Firefighters Employee Benefits Fund.

9.16 HOME HEALTH CARE

“Home Health Care” means services delivered or provided by a home health care agency.
9.17 **HOME HEALTH CARE AGENCY**

"Home Health Care Agency" means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

a) It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.

b) It has policies established by a professional group associated with the agency or organization. This professional group must include at least one physician and at least one registered nurse (RN) to govern the services provided and it must provide for full-time supervision of such services by a physician or registered nurse.

c) It maintains a complete medical record on each individual.

d) It has a full-time administrator.

9.18 **HOSPICE**

“Hospice” means an autonomous, centrally administered program which, under the direction of a licensed physician, provides a continuum of home out-patient and homelike in-patient care for the terminally ill patient, provided:

a) such care is available twenty-four (24) hours a day, seven (7) days a week;

b) the program is established and operated in accordance with the applicable laws of the jurisdiction in which it is located; and

c) where licensing is required by law, the agency or organization operating such program has been licensed and approved by the regulatory authority having responsibility for licensing under the law.

Terminally ill and terminal illness refer to medical prognosis of limited survival of six (6) months or less at the time of referral to a hospice.

9.19 **HOSPITAL**

An institution which is engaged in providing medical care and treatment to sick and injured persons on an in-patient basis at the patient's expense and which fully meets the tests set forth in (a) or (b) below:

a) It is accredited as a hospital by the Joint Commission on Accreditation of Hospital Organizations, American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities; or

b) It is an institution which fully meets all the following tests:

1) It maintains on the premises, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians;
2) It continuously provides on the premises twenty-four (24) hours a day nursing service by or under the supervision of registered graduate nurses; and

3) It is operated continuously with organized facilities for operative surgery on the premises.

c) A facility which provides medically supervised alcohol rehabilitation and meets the State requirements to provide rehabilitation as a result of alcoholism or substance abuse will be covered under this definition as a hospital.

d) A facility for the treatment of mental or nervous disorders is a hospital, or distinct part thereof, if it meets fully every one of the following tests:

1) It is approved by the Joint Commission on Accreditation of Hospital Organizations;

2) It is primarily engaged in providing, for compensation from its patients, a program for diagnosis, evaluation, and effective treatment of mental or nervous disorders. It is neither primarily a school, nor a custodial, recreational, or training institution;

3) It provides all normal infirmary level medical services required during the treatment period whether or not related to the mental or nervous disorder. It also provides, or has an agreement with a hospital in the area to provide, any other medical services required;

4) It is under the continuous supervision of a psychiatrist who has the overall responsibility for coordinating patient care and who is at the facility on a regularly scheduled basis;

5) It is staffed by psychiatric physicians who are directly involved in the treatment program, at least one of whom is present at all times during the treatment day, and continuously provides the services of a psychiatric nurse and a psychiatric social worker; and

6) It continuously provides skilled nursing services under the direction of a full-time registered nurse, with licensed nursing personnel on duty at all time.

9.20 ILLNESS

"Illness" means sickness or disease, including mental infirmity, nervous disorders, and pregnancy, which requires treatment by a physician. For newborn children, this term includes medically diagnosed congenital defects, birth anomalies, and premature birth. Illness such as those conditions incurred as described in Section 112.1815, Florida Statutes, which are considered employment-related, shall not be covered.

9.21 INCURRED EXPENSES

"Incurred Expenses" means those services and supplies rendered to a Covered Person. Such expenses shall be considered to have been incurred at the time or date the service or supply is actually provided.

9.22 INJURY

"Injury" means a bodily injury sustained accidentally by external means.
9.23 **IN-PATIENT**

“In-patient” means a person who is a resident patient using and being charged for the room and board facilities of a hospital. "Out-patient" means a person receiving services or treatment for care of sickness or injury in a hospital who is not an in-patient.

9.24 **INTENSIVE AND CORONARY CARE UNIT**

“Intensive and Coronary Care Unit” means an accommodation or part of a hospital, other than a post-anesthesia room, which in addition to providing room and board meets the following criteria:

a) Is established by the hospital for a formal intensive or coronary care program;

b) Is exclusively reserved for critically ill patients requiring constant audio-visual observation prescribed and performed by a physician or by a specially trained registered nurse; and

c) Provides all necessary life-saving drugs and supplies in the immediate vicinity on a stand-by basis.

9.25 **MANIPULATIVE SERVICES**

“Manipulative Services” include, but are not limited to, skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual, mechanical, or other means of a structural imbalance or subluxation in the human body, or treatment to remove nerve interference resulting from or related to distortion, misalignment, or subluxation of the vertebral column.

9.26 **MAXIMUM AMOUNT PAYABLE**

“Maximum Amount Payable” means the amount stated in the Schedule of Benefits for all covered expenses incurred for all accidents and sicknesses combined. All coverage under the Plan will terminate as to a Covered Person on the date the Maximum Amount is paid or becomes payable.

9.27 **MEDICALLY NECESSARY**

Services required to diagnose or treat an injury or sickness. Services must be known to be safe, effective and appropriate by most qualified practitioners who are licensed to treat that injury or sickness. Services must be performed safely at the appropriate level of care or services, and in the least costly setting required by the injury or sickness. Services must not be provided primarily for the convenience of: the patient; the patient's family; or the qualified practitioner.

9.28 **OUT-OF-POCKET**

“Out-of-pocket” expense maximum is the most an employee would pay for a Covered Person’s eligible expenses during the Plan Year. This includes the 10% or 20% co-insurance for panel providers and the 40% co-insurance for non-panel providers. This also includes benefits paid for chiropractic services of
50% for in-network providers; there is no benefit for out-of-network providers. Out-of-pocket expenses do not include deductibles, office co-payments, hospital co-payments, out-patient surgery co-payments, or co-payments for prescription drugs, co-insurances for fertility benefits, body scan benefits, or co-payments for Cord Blood or Adult Stem Cell Harvesting.

9.29 PHYSICIAN OR DOCTOR

“Physician” or “Doctor” as used in the Plan includes the following (when practicing within the scope of their valid license):

a) Doctor of Medicine (MD)
b) Doctor of Osteopathy (DO)
c) Doctor of Podiatry Medical (DPM)
d) Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD)
e) Doctor of Chiropractic (DC)
f) Doctor of Psychology (Clinical Ph.D.)
g) Certified Licensed Nurse Midwife (CLNM)
h) Licensed Mental Health Professional (LMHP)
i) Certified Licensed Advanced Registered Nurse Practitioner in Psychiatric Mental Health
j) Registered Nurse First Assistant or Physician Assistant performing surgical first assisting services in substitute of an assisting Physician.

Physician or Doctor does not include the Covered Person's dependents, spouse, parent, child, brother, or sister.

9.30 PLAN

The benefits and provisions for payment of benefits as set forth in the Plan Document of the Palm Beach County Firefighters Employee Benefits Fund.

9.31 PREGNANCY

"Pregnancy" means (1) pregnancy, (2) childbirth, (3) miscarriage, (4) any complications arising wholly from these conditions, or (5) any complications arising from a pregnancy trauma.

9.32 SECOND SURGICAL OPINION

“Second Surgical Opinion” means an opinion received prior to the performance of surgery from a second physician, licensed to practice medicine and perform surgery, who is not related or financially associated with the first qualified physician who recommended the elective surgery based on examination of the Covered Person, regarding the advisability of the elective surgical procedure proposed by the first qualified physician. An opinion by a physician who is not qualified to perform surgery is not considered a surgical opinion.
9.33 **SEMI-PRIVATE ROOM RATE**

“Semi-private Room Rate” means the charge made by a hospital for a room which does not exceed the hospital's daily charge for its greatest number of rooms containing two or more beds.

9.34 **SKILLED NURSING FACILITY**

“Skilled Nursing Facility” means an institution which (1) provides skilled nursing care under 24-hour supervision of a doctor or graduate Registered Nurse, (2) has available at all times the services of a doctor who is a staff member of a hospital, (3) provides 24-hours-a-day nursing service by a graduate Registered Nurse, Licensed Vocational Nurse, or skilled practical nurse and has a graduate Registered Nurse on duty at least eight (8) hours per day, (4) maintains a daily medical record for each patient, (5) is neither a place for rest or custodial care for the aged, for drug addicts or alcoholics, nor a hotel or similar facility.

9.35 **TOTAL DISABILITY**

A Covered Employee is totally disabled only if he/she is under a physician's care and is completely prevented by a sickness or injury from engaging in any occupation for which he/she is qualified, or becomes qualified by reason of education, training or experience. A dependent must be prevented from carrying on normal activities of a person of like age, sex, education, training, or experience to be considered totally disabled.

9.36 **TRUSTEES**

“Trustees” means the Board of Trustees of the Palm Beach County Firefighters Employee Benefits Fund.

9.37 **USUAL, CUSTOMARY AND REASONABLE CHARGE (UCR)**

“Usual, Customary, and Reasonable Charge” means the prevailing fee for a non-panel/non-exclusive providers, or fee most frequently charged by the providers with similar training and experience for the performance of a comparable service, or a service of comparable gravity, severity and magnitude, in the locality where the service was performed.

9.38 **MORBID OBESITY**

“Morbid obesity” is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age, and mobility as the Covered Person. The standards set in the Metropolitan Life Insurance Table are used in helping to determine medically recommended weight. “Morbid obesity” may also be defined as a condition in which the body has a body mass index (BMI) of over 40, or a BMI of 35 up to 40, along with two or more associated co-morbid conditions, which are: cardiovascular disease, cardiopulmonary problems, musculoskeletal dysfunction:
9.39 **SPINAL DISC DECOMPRESSION**

Spinal Disc Decompression is a physical therapy designed to correct disc problems in the spine without drugs or surgery.

9.40 **AUTISM SPECTRUM DISORDER**

Autism spectrum disorder means any of the following disorders as defined in the most recent edition of the Diagnostic Statistical Manual of Mental Disorders of the American Psychiatric Association: Autistic Disorder, Asperger’s Syndrome, Pervasive developmental disorder not otherwise specified.

9.41 **BENEFITS ADMINISTRATOR**

The Benefits Administrator is the person employed by the Board of Trustee’s to do the day to day business of The Fund and normally works in The Fund office.

9.42 **PLAN ADMINISTRATOR**

The Plan Administrator shall be the Board of Trustees
10. **SCHEDULE OF BENEFITS** (effective January 1, 2011)

<table>
<thead>
<tr>
<th>Services obtained from PPO Panel Providers</th>
<th>Services from Non-Panel/Non-Exclusive Providers</th>
</tr>
</thead>
</table>

**10.1 Lifetime Maximum Benefits:**

- Eyeglasses following Cataract Surgery (one time purchase)  
  - $400

- Hospice  
  - $5,000

- Autism Spectrum Disorder  
  - $200,000

- In-Vitro Fertilization/Artificial Insemination  
  - $5,000 per person covered at 50% (see Subsection 11.8(c)(36) for further information)
  - Not Covered.

**10.2 Eight Calendar Years Maximum:**

- Orthotics  
  - $1,200

**10.3 Calendar Year Maximum:**

- Out-of-Pocket (per person)  
  - $1,000
  - $35,000

- Out-of-Pocket (maximum per family)  
  - $2,500
  - $35,000

- Calendar Year Deductible-Per Person (excluding Hospital Admission)  
  - $0
  - $500

- Maximum Per Family (excluding Hospital Admission)  
  - $0
  - $1,000

- Private Duty Nursing  
  - $2,000
  - $2,000
<table>
<thead>
<tr>
<th>Service</th>
<th>Maximum Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care</td>
<td>60 days</td>
</tr>
<tr>
<td>Manipulative Services</td>
<td>$ 650</td>
</tr>
<tr>
<td>Autism Spectrum Disorder</td>
<td>$ 36,000</td>
</tr>
<tr>
<td>Alcohol and Substance Abuse Treatment</td>
<td>$ 750,000</td>
</tr>
<tr>
<td>Mental &amp; Nervous Conditions (out-patient)</td>
<td>$ 750,000</td>
</tr>
<tr>
<td>10.4 Major Medical Benefits</td>
<td>PPO Panel Pro</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>Covered at 80% after $400 per hospital admission co-pay has been applied, maximum two (2) co-pays per calendar year, individual or family. All admission require notification from your PPO Panel Provider (please see Section 5, above). In the absence of such pre-admission notification, except for an emergency, a $100 penalty will be assessed to your provider. The $400 per hospital admission co-pay will be waived for subsequent hospital admissions if the covered plan participant is re-admitted for the same condition within 31 days of the previous admission.</td>
</tr>
<tr>
<td>Room &amp; Board</td>
<td>Average Semi-Private</td>
</tr>
<tr>
<td>Physician &amp; Surgeon</td>
<td>Covered at 90%</td>
</tr>
<tr>
<td>Office Visits</td>
<td>Covered at 100% subject to a $20 office co-payment at a PCP (OB/GYN, Pediatrician, General Practice, Family Practice, Internist) or a $30 Office co-payment at a Specialist. Related services performed for this benefit shall be paid at 90%.</td>
</tr>
<tr>
<td>Urgent Care and Walk-In Clinics</td>
<td>Covered at 100% (subject to a $30 co-pay)</td>
</tr>
</tbody>
</table>
### Annual Adult Health Maintenance Guidelines for Non-Fire Rescue Participants

(Appplies to Other Employees*, Spouses, Dependents and Retirees Only)

Covered at 100% for PPO Panel Providers without a co-payment and 0% for non-PPO Panel Providers

<table>
<thead>
<tr>
<th>Physical Exams</th>
<th>18-25 years</th>
<th>26-39 years</th>
<th>40-49 years</th>
<th>50-65 years</th>
<th>65 + years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height, weight, total body assessment</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>Every 3 yrs</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
</tr>
<tr>
<td>EKG</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
</tr>
</tbody>
</table>

* Other Employees shall be defined as covered non-fire rescue employees

### Annual Adult Health Maintenance Guidelines For All Participants

Covered at 100% for PPO Panel Providers without a co-payment; Covered at 0% for Non-PPO Panel Providers

<table>
<thead>
<tr>
<th>Screenings</th>
<th>17-25 years</th>
<th>26-39 years</th>
<th>40-49 years</th>
<th>50-65 years</th>
<th>65 + years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy, or Tomographis Colonography (virtual colonoscopy)</td>
<td>Every 10 yrs</td>
<td>Every 10 yrs</td>
<td>Every 10 yrs</td>
<td>Every 10 yrs</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>Baseline</td>
<td>Every 2 yrs</td>
<td>Every 2 yrs</td>
<td>Every 2 yrs</td>
<td>Annually</td>
</tr>
<tr>
<td>Mammography or Digital Infrared Thermal Imaging (DITI)</td>
<td>Baseline</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
</tr>
<tr>
<td>GYN, Pap, Urinalysis (“Well Women Benefit”)</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td>18-25 years</td>
<td>26-39 years</td>
<td>40-49 years</td>
<td>50-65 years</td>
<td>65 + years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Labs</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General Panel – Thyroid, CMP*, CBC**</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
</tr>
<tr>
<td>Lipid Panel</td>
<td>Age 20</td>
<td>Every 5 yrs</td>
<td>Every 5 yrs</td>
<td>Every 5 yrs</td>
<td>Every 5 yrs</td>
</tr>
<tr>
<td>Prostate PSA</td>
<td>Age 30</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
</tr>
<tr>
<td>Hepatitis Panel***</td>
<td>Age 35</td>
<td>See below***</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immunizations</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus/Diphtheria</td>
<td>Every 10 yrs</td>
<td>Every 10 yrs</td>
<td>Every 10 yrs</td>
<td>Every 10 yrs</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>Age 50</td>
<td>Every 7-10 yrs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A &amp; B</td>
<td>Every 10 yrs</td>
<td>Every 10 yrs</td>
<td>Every 10 yrs</td>
<td>Every 10 yrs</td>
<td></td>
</tr>
</tbody>
</table>

* CMP – Complete metabolic panel consisting of, electrolytes, chemistry, and glucose
** CBC – Complete blood count – (red & white)
*** Hepatitis Panel - If abnormality found, every six months, then annually

Refer to Subsection 11.8 if you have any further questions as to what is covered under the Plan.

Additional information as to covered Preventative Benefit items are listed in the Appendix
<table>
<thead>
<tr>
<th>Services obtained from PPO Panel Providers</th>
<th>Services from Non-PPO Panel Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Room Facility</strong></td>
<td>Covered at 60% subject to a $50 co-payment; $50 co-payment waived if ER visit results in hospital admission within 24 hours.</td>
</tr>
<tr>
<td>Subject to a $50 co-payment; Covered at 80%; $50 co-payment waived if ER visit results in hospital admission within 24 hours.</td>
<td>Benefits will be payable as if rendered by a PPO provider for emergencies, or when services are not available through a PPO panel provider.</td>
</tr>
<tr>
<td><strong>Out-Patient Medical</strong></td>
<td>Covered at 60% of UCR. Deductible applies.</td>
</tr>
<tr>
<td>Covered at 90%</td>
<td>Covered at 60% of UCR. Deductible applies.</td>
</tr>
<tr>
<td><strong>Supplemental Accident</strong></td>
<td>100% of first $300 per accident, with the balance applied to Major Medical. $50 co-payment is required after first $300, thereafter Covered at appropriate benefit level (provider or hospital). Applies to Emergency Room or Urgent Care Facility visits only.</td>
</tr>
<tr>
<td>100% of first $300 per accident, with the balance applied to Major Medical. Calendar Year deductible applies after first $300, thereafter covered at 60%. Applies to Emergency Room or Urgent Care Facility visits only.</td>
<td>100% of first $300 per accident, with the balance applied to Major Medical. Calendar Year deductible applies after first $300, thereafter covered at 60%. Applies to Emergency Room or Urgent Care Facility visits only.</td>
</tr>
<tr>
<td><strong>Pre-Hospital Admission Testing</strong></td>
<td>Covered at 90% Deductible applies.</td>
</tr>
<tr>
<td>Covered at 90%</td>
<td>Covered at 60% Deductible applies.</td>
</tr>
<tr>
<td><strong>Out-patient Surgery Co-Pay</strong></td>
<td>$200 co-payment, thereafter covered at 90%.</td>
</tr>
<tr>
<td>$200 co-payment, thereafter covered at 90%.</td>
<td>$200 co-payment, thereafter covered at 60%. Deductible applies.</td>
</tr>
<tr>
<td><strong>Private Duty Nursing</strong></td>
<td>Covered at 80% up to Calendar Year maximum.</td>
</tr>
<tr>
<td>Covered at 60% of UCR up to Calendar Year maximum.</td>
<td>Covered at 60% of UCR up to Calendar Year maximum. Deductible applies.</td>
</tr>
<tr>
<td><strong>Manipulative Services</strong></td>
<td>Covered at 50%</td>
</tr>
<tr>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Including associated x-rays, diagnostics tests, and laboratory charges up to the calendar year maximum of $650; and subject to the office visits co-payment of $20.</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage Details</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Covered at 90%</td>
</tr>
<tr>
<td></td>
<td>Covered at 60%</td>
</tr>
<tr>
<td>Spinal Disc Decompression</td>
<td>The application of a modality that does not require direct (on-on-one) patient</td>
</tr>
<tr>
<td></td>
<td>contact by the provider (physical therapy designed to correct disc problems in</td>
</tr>
<tr>
<td></td>
<td>the spine without drugs or surgery) shall be a benefit available to all</td>
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<tr>
<td></td>
<td>participants. Participants shall be eligible to receive mechanical traction for</td>
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<td></td>
<td>20 sessions maximum per calendar year by an in-network provider only. All</td>
</tr>
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<td></td>
<td>treatment received on the same day as a Spinal Disc Decompression shall be</td>
</tr>
<tr>
<td></td>
<td>subject to this benefit, subject to the requirement that the treating provider</td>
</tr>
<tr>
<td></td>
<td>be in-network. Covered at 90%.</td>
</tr>
<tr>
<td>Foot Orthotics</td>
<td>Covered at 80% subject to every eight (8) years maximum up to $1200.</td>
</tr>
<tr>
<td></td>
<td>Covered at 60% of UCR subject to every eight (8) years maximum up to $1200.</td>
</tr>
<tr>
<td></td>
<td>Deductible applies.</td>
</tr>
<tr>
<td>Eyeglasses following</td>
<td>Covered at 100% up to $400 for a one time charge without limit to the number of</td>
</tr>
<tr>
<td>Cataract Surgery</td>
<td>glasses purchased.</td>
</tr>
<tr>
<td></td>
<td>Covered at 100% up to $400 for a one time charge without limit to the number of</td>
</tr>
<tr>
<td></td>
<td>glasses purchased.</td>
</tr>
<tr>
<td>Home Health Care Benefit</td>
<td>Covered at 80%. Up to 60 days per Calendar Year.</td>
</tr>
<tr>
<td></td>
<td>Covered at 60% of UCR. Up to 60 days per Calendar Year. Deductible applies.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Covered at 80%</td>
</tr>
<tr>
<td></td>
<td>Covered at 60% of UCR. Deductible applies.</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Covered at 80% subject to lifetime maximum.</td>
</tr>
<tr>
<td></td>
<td>Covered at 60% of UCR subject to lifetime maximum. Deductible applies.</td>
</tr>
</tbody>
</table>
### Mental & Nervous Condition (In-patient)

Covered at 80%; Illness such as those conditions incurred as described in Section 112.1815, Florida Statutes, which are considered employment-related, shall not be covered. Covered at 60% of UCR. Deductible applies. Illness such as those conditions incurred as described in Section 112.1815, Florida Statutes, which are considered employment-related, shall not be covered.

For in-patient hospital services or partial hospitalization services, the Plan will pay all related eligible expenses.

### Mental & Nervous Conditions (Out-Patient)

For out-patient treatment, benefits are payable at 50% up to a maximum of $750,000.00 per Calendar Year. This 50% benefit also applies to a psychometric testing and psychotherapy. Illness such as those conditions incurred as described in Section 112.1815, Florida Statutes, which are considered employment-related, shall not be covered.

### Alcohol & Substance Abuse (In-Patient and Out-Patient)

Covered at 80%. Up to a maximum of $750,000 per calendar year. Covered at 60% of UCR. Up to a maximum of $750,000 per calendar year. Deductible applies. Benefits will be reduced by 100% for failure of the Covered Person to complete all facets of the program.

For out-patient services, benefits are payable to a maximum eligible office visit expense of $100 per visit, payable at 50%. Benefits for services provided through the Fire Department Employee Assistance Program are payable up to $70 with no co-payment. Benefits are limited to the Calendar Year Maximum benefit of $750,000. Detoxification shall not be considered as an Eligible Expense under the out-patient program.

### Autism Spectrum Disorder

Covered at 80% up to Calendar Year maximum. Covered at 60% of UCR up to Calendar Year maximum. Deductible applies.

### Well Baby Care

In connection with the delivery of a newborn dependent, eligible for coverage under the Plan, charges for routine nursing or well-baby care (crib care) will be payable at 80%; The $400 in-patient deductible is waived.

In connection with the delivery of a newborn dependent, eligible for coverage under the Plan, charges for routine nursing or well-baby care (crib care) will be payable at 60%. Deductible applies.
Full CT Body Scan (with Carotid Artery Ultrasound) for Covered Employees and retirees

$650 flat fee payable by the Fund once every five (5) years.

Full CT Body Scan (with Carotid Artery Ultrasound) for Covered Spouses

Up to fifty percent (50%) for Covered Spouses up to four hundred dollars ($400) performed at Wellness Center of Florida or another approved provider once every five years. Wellness Associates shall bill the entire $800 rate to the Fund, and the provider shall charge the Covered Spouse $400 for such benefit, provided that a Comprehensive Consultation and Risk Evaluation is performed. Failure to obtain a Comprehensive Consultation and Risk Evaluation shall result in 100% reduction of benefit. If dependent is also an employee of Palm Beach County Fire Rescue, or retired member, a body scan is payable pursuant to the paragraph above.

Comprehensive Consultation and Risk Evaluation for Covered Employees and retirees

In connection with a Full CT Body Scan, charges for a review of the scan correlated with an annual physical (laboratory results and EKG) are payable at a flat fee of $150 by the Fund.

For those eligible plan participants who elect to undergo screening at the Wellness Associates of Florida, a body scan facility located in Atlantis, Florida, the rate is $650; the benefit would therefore be covered at 100%.

Similarly, for those who elect to undergo a Comprehensive Consultation and Risk Evaluation at the Wellness Associates of Florida, the rate is $150; the benefit would therefore be covered at 100%.

Other Covered Medical Expenses

Covered at 90%

Covered at 60% of UCR.

Deductible applies.
Out-of-Pocket Maximum (see Definition section)  
If during a calendar year, the eligible out-of-pocket expense exceeds $1,000 per Covered Person or $2,500 per family, any additional eligible expenses will be payable at 100% for the remainder of the Calendar Year. 
If, during one Calendar Year, the eligible out-of-pocket expense exceeds $35,000 per Covered Person, any additional covered expenses will be payable at 100% of the remainder of the Calendar Year.

Cord Blood (Stem Cell)  
Covered at 100% after a $100 non-refundable co-pay, includes harvesting and annual storage for 18 years, at the Stem Cell Cryobank, LLC (“SCC”), or at a different facility but benefit limited to an amount equal to ($2400)(service must be fully pre-paid for 18 years)

Adult Stem Cell Harvesting  
Covered at 50% at the South Florida Bone Marrow Stem Cell Transplant Institute, LLC (“SFBMSCTI”)

Adult Stem Cell Storage  
Covered at 100% at the Stem Cell Cryobank, LLC (“SCC”)
10.5 Prescription Drug Plan:

Retail (30 day supply)
Co-pay  Generic - $0  Formulary Brand - $25  Non-Formulary Brand - $50
      Brand w/Generic Available - $50 plus difference in cost*

Mail-in (maximum 90 day supply)
Co-pay  Generic - $0  Formulary Brand - $50  Non-Formulary Brand - $80
      Brand w/Generic Available - $80 plus difference in cost*

*If the patient or their physician requests a brand name drug instead of its generic equivalent, the member will be charged
the brand copay plus the difference between the brand name drug and the generic copay.

Generic Drugs will be mandatory whenever a generic drug is available unless a Letter of Medical Necessity is provided
by the prescribing doctor.

Specialty Drugs will be subjected to Sav-Rx’s Utilization Management Program including, but not limited to, prior
authorization being required, “30 day supply limit”.

A Step Therapy Program will be required for the following drug classes: osteoporosis (biphosphonates), cholesterol-
lowering (statins), sleep aids and steroid nasal sprays.

The Step Therapy Program shall “grandfather” the following classes of drugs: osteoporosis (biphosphonates), cholesterol-
lowering (statins), sleep aids and steroid nasal sprays. “Grandfather” shall mean all prescription claims within the last six
months (July 1st, 2010 - December 31st, 2010). All new prescriptions shall be included in the Step Therapy Plan.
11. DESCRIPTION OF BENEFITS

11.1 PREGNANCY

If a Covered Employee or the covered dependent of a Covered Employee incurs pregnancy-related medical expenses, the Plan shall pay the benefits on the same basis as any other medical conditions subject to the Schedule of Benefits. Pregnancy shall be deemed to have commenced nine months prior to its termination, unless a different commencement date is established by a doctor's written statement.

Services rendered by licensed midwives and certified nurse midwives in the State of Florida, and the services of birthing centers licensed by the State of Florida, are Eligible Expenses.

The length of a maternity and newborn stay in a hospital or for follow-up care outside of a hospital will be covered and shall not be shorter than that period determined to be medically necessary by the treating obstetrical care provider or the pediatric care provider, in accordance with prevailing medical standards and consistent with guidelines for perinatal care of the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists.

Coverage includes post delivery care for a mother and her newborn infant. Post-delivery care includes a postpartum assessment and newborn assessment provided at the hospital, attending physician’s office, an outpatient maternity center, or in the home of a qualified and trained licensed health care professional. Services include physical assessment of the newborn and mother, medically necessary clinical tests, and immunizations.

11.2 SUPPLEMENTAL ACCIDENT EXPENSE BENEFIT

These benefits are payable if a Covered Person sustains accidental injury and incurs expenses at an Emergency Room Facility or Urgent Care Facility within seven (7) days after the accident for charges made for hospital, medical or surgical services, or services of a licensed nurse (an R.N. or L.P.N. not related to or living with the Covered Person) that are necessary for the diagnosis and treatment of such injury and recommended or approved by an attending physician.

Benefits payable: 100% of covered medical expenses up to $300.00, not subject to a deductible. After $300.00 in benefits are paid, benefits will be paid as stated in the Schedule of Benefits.

Additional Exclusions: No Benefits are payable under this provision of the Plan for Dental services of any kind.

11.3 CHILD HEALTH SUPERVISION SERVICES

“Child health supervision services” means physician-delivered or physician supervised services, that include periodic visits which include a history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests which services and periodic visits shall be provided in accordance with prevailing medical standards. At each periodic visit, benefits are limited to those rendered at one (1) visit, payable to one (1) provider for all eligible services.

Child health supervision services are payable for covered dependent child(ren) of a Covered Person from the moment of birth to age 18 years without application of copay or deductible. Such services and periodic visits may be provided at approximately the following age intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years,
16 years, and 18 years, in accordance with prevailing medical standards and consistent with the Recommendations for Preventative Pediatric Health Care of the American Academy of Pediatrics.

Child health supervision services shall also include one (1) child sports physical per year for children in grades Kindergarten through twelve (12) as stated in Section 1002.20(17)(b), Florida Statutes, which states that, “Students must satisfactorily pass a medical evaluation each year before participating in athletics, unless the parent objects in writing based on religious tenets or practices, in accordance with the provisions of [section] 1006.20(2)(d).” Accompanying proof may be required by UMR if the physical is performed during an age interval not covered in the preceding paragraph, or if in addition to services under the covered age intervals in the preceding paragraph, or to verify the child sports physical. College physicals are not covered under this provision (see Section 6.2).

11.4 HOME HEALTH CARE BENEFIT

These benefits are payable for up to sixty (60) days per Calendar Year for Home Health Care Services which commence within three (3) days following a hospital confinement.

Medical expenses incurred by a Covered Person for charges made by a Home Health Care agency, are only eligible for coverage provided the home health care treatment is:

a) supervised by a duly qualified physician who has certified the need for treatment;

b) commences within three (3) days following the Covered Person's discharge from a hospital; and

c) is being provided in lieu of continued hospital care.

The following services and supplies furnished in a patient’s home by a Health Care Agency under a plan of treatment prescribed by a licensed physician, but only to the extent that such services and supplies approved by the supervising physician and would have been considered covered medical expenses if the Covered Person had been confined in a hospital:

a) part-time or intermittent nursing care by a registered graduate nurse or licensed practical nurse;

b) part-time or intermittent home health care aid services consisting of patient care of a medical or therapeutic nature performed by a home health aid;

c) physical therapy, occupational therapy, and speech therapy performed by physical therapist, a speech therapist, or occupational therapist;

d) medical supplies and laboratory services ordered by a physician; and

e) drugs legally obtained by a physician's written prescription.
11.5 **NERVOUS OR MENTAL DISORDERS**

If a Covered Person incurs expense for covered charges as a result of a nervous or mental disorder, benefits are payable for in-patient hospital services, partial hospitalization services, out-patient services, and/or intensive outpatient services for all related Eligible Expenses.

For out-patient treatment, benefits are payable at 50%, up to a maximum of $750,000.00 per Calendar Year including psychometric testing and psychotherapy.

Benefits for services provided through the Fire Department Employee Assistance Program (“EAP”) Coordinator are payable up to $70 with no co-payment. When a Covered Person seeks treatment through the EAP Coordinator and an EAP referral is made to a facility for treatment, the charges incurred by the Covered Employee at that facility will be considered Eligible Expenses for coverage under the Plan, subject to any and all Plan limitations and maximum benefits.

11.6 **ALCOHOL AND SUBSTANCE ABUSE**

Benefits are payable for in-patient services, partial hospitalization, halfway houses, and/or intensive outpatient alcohol and substance abuse services subject to an annual maximum benefit of $750,000 Benefits will be reduced by one-hundred percent (100%) for failure of the Covered Person to complete all facets of the program.

For out-patient treatment, office visits payable at 50%, for up to a maximum of $750,000 per Calendar Year, not subject to a deductible.

Detoxification shall not be considered as an Eligible Expense under the out-patient program.

Benefits for services provided through the Fire Department Employee Assistance Program (“EAP”) Coordinator are payable up to $70 with no co-payment. When a Covered Person seeks treatment through the EAP Coordinator and an EAP referral is made to a facility for treatment, the charges incurred by the Covered Person at that facility will be considered Eligible Expenses for coverage under the Plan, subject to any and all Plan limitations and maximum benefit.

11.7 **MAJOR MEDICAL BENEFITS**

When accidental bodily injury or sickness causes a Covered Person to incur Hospital-Surgical-Medical expenses, the Plan will pay the applicable percentage of the Eligible Expenses incurred as a result of said injury or sickness. Said benefits will be payable only after application of the applicable Deductible Amount and up to the Maximum Amount payable, as stated in the Schedule of Benefits.

The “Deductible Amount” shall be the total of the cash amount specified in the Schedule of Benefits. Such Deductible Amount must first be satisfied each Calendar Year by the application of expenses incurred as listed below before any such expenses incurred will be payable as benefits under the Plan.

Expenses incurred during the three (3) month period immediately preceding the current Calendar Year which were applied to the Deductible Amount for the preceding Calendar Year will be included as expenses incurred for the current Calendar Year, and applied to the Deductible Amount for the current Calendar Year.
For Covered Employees with dependent coverage, after $1,000 in deductibles has been satisfied, covered expenses incurred by any other family member during the remainder of that Calendar Year will not be subject to the deductible.

In the event more than one Covered Person in the same family is injured by reason of any one accident, or in the event a Covered Person contracts a contagious disease which is otherwise covered hereunder, and any other Covered Person or Persons in the same family contracts the same disease within thirty (30) days thereafter, only one (1) deductible will be applied to all such Covered Persons as the result of such accident or contagious disease.

11.8 **ELIGIBLE EXPENSES**

“Eligible Expenses” are the following, not in excess of the reasonable and customary charges, for the services rendered or the supplies furnished, actually for or on account of a Covered Person, which are medically necessary and ordered by a physician for the care and treatment of accidental bodily injury or sickness:

a) Hospital Expenses for daily room and board (up to average semi-private) and the following other hospital expenses required for medical or surgical care or treatment: Operating room, medicines, drugs, unreplaced blood and blood plasma (including administration thereof), anesthetic (including administration thereof in a hospital by a physician and surgeon), x-ray examinations, radiation treatments, physiotherapy, laboratory tests, surgical dressings, and medical supplies;

b) Surgical Expenses for the performance of medically necessary surgical procedures, including oral surgery only when performed due to medical necessity (including necessary related post-operative care) by physicians;

c) Additional Expenses, if not included under Subsections (a) and (b) above for:

1) Treatment by a physician;

2) Out-patient treatment of mental, psychoneurotic, or personality disorders by a physician, a licensed psychologist, or a licensed mental health professional practicing within the scope of their license shall be limited to 50% up to a maximum annual benefit of $750,000. In cases of services provided through the Fire Department Employee Assistance Program Coordinator, benefits are limited to $70 per visit with no co-payment;

3) Services of a licensed registered graduate nurse or a licensed practical nurse rendered in or out of a hospital, or a licensed undergraduate nurse for services rendered only in a hospital, provided such services are not rendered by a person in the Covered Person's immediate family (that is the Covered Person's spouse, children, brothers, sisters and parents), not to exceed $2,000 in Eligible Expenses during any Calendar Year;

4) Anesthetic and its administration (other than local infiltration or digital block anesthesia);

5) Treatment for physical, speech, and occupational therapy provided by a licensed therapist (other than a member of the Covered Person's immediate family defined above) for rehabilitation or habilitation of an injury or sickness;
6) Dental treatment by a physician for a fractured jaw, for injury to sound natural teeth, including replacement of such teeth within six (6) months after the date of the accident if medically feasible, or resulting from, or due to medically necessary treatment covered by this Plan;

7) Services and supplies as a result of or in connection with an elective abortion under the circumstances of rape or incest; sterilization procedures

8) X-ray, radium, or chemotherapy treatment;

9) X-ray and laboratory examinations, excluding dental x-rays unless rendered for dental treatment provided for in paragraph (6);

10) Ambulance charges for necessary local transportation of a Covered Person by professional ambulance service to the nearest hospital for in-patient care, or to the nearest hospital for emergency care where the necessary treatment is available. In cases of life threatening sickness or injury, air ambulance services are permitted only to the nearest hospital providing the necessary facilities. Air transportation of a newborn child for care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, certified by the attending physician, to the nearest available facility and appropriately staffed and equipped to treat such newborn child(ren);

11) Medical Supplies, including legend drugs and medicines dispensed by a licensed pharmacist [only under the prescription drug card program]; blood and blood plasma, artificial limbs and eyes (including replacements when determined to be medically necessary) surgical dressings, casts, splints, trusses, braces, and crutches. Prosthetics over $1,000 will require notification;

12) Rental of durable medical equipment required for temporary therapeutic use, or purchase when more economical than rental, subject to prior approval by the Benefits Administrator. Rental charge benefits cannot exceed the purchase price. Durable medical equipment over $500 per month for rental and $1,500 for purchase will require notification;

13) The initial corneal lens following cataract surgery;

14) In connection with a mastectomy, for reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses and other charges relating to physical complications at all stages of the mastectomy, including lymphedemas, consistent with prevailing medical standards and in consultation with the patient;

15) A routine gynecologic examination once per Calendar Year that includes a mammogram/Digital Infrared Thermal Imaging (DITI) and pap smear, blood work, and urinalysis;

16) Routine ultrasound plus amniocentesis if deemed to be medically necessary;

17) Home Uterine Activity Monitoring;
18) Hepatitis B Inoculation except if Covered Person is eligible for a free Hepatitis B Inoculation through Palm Beach County;

19) Full series (3-dose) Human papillomavirus (HPV) Inoculation for participants, ages 9 through 26, provided that if first dose is received during participant’s 26th year the second and third dose may be given later than age 26, in accordance with recommended guidelines;

20) The purchase and fitting of orthotics up to $1,200 subject to the Schedule of Benefits;

21) Medically appropriate and necessary equipment, supplies, out-patient self-management training and educational services related to the treatment of diabetes, if the Covered Person's treating physician who specializes in the treatment of diabetes certifies that such services are necessary. Diabetes out-patient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist. Nutrition counseling must be provided by a licensed dietician;

22) The first set of eyeglasses after cataract surgery up to $400.00 subject to the Schedule of Benefits;

23) The medically necessary diagnosis and treatment of osteoporosis for high-risk individuals (i.e., estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism and individuals who have a family history of osteoporosis);

24) Diagnostic or Surgical procedures involving bones or joints of the jaw and facial region if such procedure or surgery is medically necessary to treat conditions caused by congenital or developmental deformity, disease, or injury;

25) Birth control dispensed by a physician;

26) Cochlear implants in accordance with the guidelines set forth by Medicare;

27) Medically necessary reduction mammaplasty. Symptoms must include three or more of the following documented criteria: a) chronic back, upper neck, and shoulder pain; b) grooving of the shoulder area; c) upper extremity paresthesia; d) headaches; e) intertrigo (breast rash). Medical necessity will also be determined based on the amount of breast tissue to be removed (including severity of breast hypertrophy as determined by a medical consultant), height and weight of the individual, bra size, any failed treatment plans (physical therapy, diet, and exercise). A comprehensive physical and history along with photographs must be included in the documentation;

28) A newborn child of a non-spousal dependent from the moment of birth to the age of eighteen (18) months, limited to those coverages required under § 627.6575(2), Fla. Stat.;

29) Full CT Body Scan (with Carotid Artery Ultrasound) for Covered Employees and retirees, subject to the Schedule of Benefits;
30) Annual physicals for eligible other employees, spouses, dependants and retirees only as provided in the Annual Adult Maintenance Guidelines for Non-Fire Rescue Participants, located in Section 10.4 “Major Medical Benefits”;

31) Full CT Body Scan (with Carotid Artery Ultrasound) for Covered Employees’ Spouses. Up to fifty percent (50%) for Covered Employees’ Spouses up to four hundred dollars ($400) performed at Wellness Associates of Florida or another approved provider once every five years;

32) Charges incurred as a result of or in connection with the pregnancy of a covered dependent child (charges related to the newborn child of a non-spousal dependent still are governed by Subsection 11.8(c)(28) of this Plan Document and Summary Plan Description);

33) Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavior analysis, which shall be provided by an individual certified pursuant to Florida law. This coverage is subject to all other provisions of this Plan, including annual and lifetime benefits limits as stated in Subsection 10.4, and shall not be denied on the basis that provided services are habilitative in nature;

34) Preventative colonoscopy or Tomographic Colonography (virtual colonoscopy) examination pursuant to the Annual Adult Health Maintenance Guidelines For All Participants (page 21);

35) Telephonic appointments with Physician or Doctor as defined by this Plan, when deemed “Medically Necessary” as defined by this Plan. Doctor or Physician shall not charge more than the Usual, Customary and Reasonable Charge, as defined by this Plan, for such benefit. The Plan Administrator may require written proof of medical necessity;

36) Any artificial means to achieve pregnancy including, but not limited to, in vitro fertilization, GIFT, ZIFT, artificial insemination and all related fertility testing, treatment and drugs, up to $5,000 lifetime per person, and covered at 50% with a PPO panel provider only. Participants shall pay up front for the prescription benefit and claims shall be submitted to the Claims Administrator for reimbursement.

37) Medical treatment for abnormally short stature that is recognized as conforming to accepted medical practice and/or is a safe, effective standard of medical practice, pursuant to FDA guidelines;

38) Any and all cost saving alternative treatment or services which the third party claims administrator, case manager, or stop loss insurance carrier, or insurance consultant recommended to the Board and approved by the Board to be in the best interest of the Plan.

39) Hearing exams when deemed Medically Necessary.

40) PPO benefits will be payable for Non-PPO provider services only if you receive treatment this is a covered expense from a PPO provider and as a result of the treatment, a covered expense is
incurred from a Non-PPO provider that is a pathologist; anesthesiologist; cardiologist; radiologist; or emergency room physician.

41) In cases where a participant is balanced billed by a non-panel/non-exclusive provider for charges over UCR received in a PAR facility and it is brought to the attention of the Fund, the Fund and/or the member will attempt to negotiate with the provider to reduce the excess charges and then the Fund may elect to cover the balance, at the same percentage as the original claim. For cases where the over UCR charge from any one provider is in excess of $1,000 UMR will first attempt to negotiate with the provider.

Provided, however, that no expense incurred shall be payable or included in any computation of payment under more than one of the above categories.
12. SPECIAL PROVISIONS

12.1 PRE-EXISTING CONDITION EXCLUSIONS

“Pre-existing Condition” means a physical or mental condition for which medical advice, diagnosis, care or treatment was sought, recommended, or received by the affected person within the six-month period, ending on the person’s enrollment date in the Plan or the first day of the waiting period.

If a Covered Person, over the age of 19, has a pre-existing condition, their coverage for the specific condition will not begin until that person:

a) has not received any medical services or drugs for such a condition for six (6) consecutive months while covered under this Plan; or

b) has been covered by the Fund for at least twelve (12) months or eighteen (18) months in the case of a “Late Enrollee,” from the enrollment date or the first day of the waiting period.

The exclusion period shall be reduced if the Covered Person demonstrates prior coverage without an intervening break of more than sixty-three (63) days. Waiting periods do not count as significant breaks in coverage. Days of coverage that occur before a sixty-three (63) day break in coverage are not counted as creditable coverage. For each month of prior coverage, the exclusion period is reduced by one month. Prior coverage includes coverage under group health plans, individual policies, HMOs, Medicare and governmental programs. Periods of prior coverage shall be established through presentation of certificates issued by the prior insurer.

No exclusion for a pre-existing condition will be imposed on newborn adopted children if coverage is applied for within thirty (30) days of birth, adoption, or placement for adoption. No exclusion for a pre-existing condition will be imposed on pregnancy for a Covered Employee or the covered dependent spouse of a Covered Employee. No pre-existing conditions will be imposed for any dependent under the age of 19.

This Plan will furnish a certificate of creditable coverage, specifying coverage dates, to the following:

a) a qualified beneficiary upon a qualifying event which entitles him or her to elect continuing coverage, no later than the time the continuing coverage election notice is required to be furnished;

b) an individual who loses coverage and who is not a qualified beneficiary entitled to elect continuation coverage, within a reasonable time after coverage ceases; and

c) a qualified beneficiary who has not elected continuation coverage, after either cessation of continuation coverage or, if applicable, after the expiration of any grace period for the nonpayment of premiums.

As for other situations, a certificate is required to be provided upon the request of, or on behalf of, an individual not later than 24 months after the individual loses coverage.
12.2 ORGAN OR TISSUE TRANSPLANT SERVICES

(a) Subject to all terms and conditions of the Plan, medical expenses incurred as a result of human-to-human organ or tissue transplant services will be payable for the Covered Person/recipient on the same basis as any other covered surgical procedure for the following services:

Artery or vein transplants, and cornea transplants, when provided from a human donor to a living human recipient.

(b) The following human organ or tissue transplants must be provided from a human donor to a living human recipient:

1. bone marrow transplants;
2. heart transplants;
3. heart/lung transplants (combined procedures);
4. kidney transplants;
5. liver transplants;
6. lung transplants;
7. pancreas transplants; and
8. pancreas/kidney transplants (combined procedures).

NOTE: THE PLAN SHOULD BE NOTIFIED OF A POTENTIAL TRANSPLANT AS SOON AS YOU ARE AWARE OF THE POSSIBILITY OF A TRANSPLANT BEING NECESSARY FOR YOU. ACCESS TO THE TRANSPLANT NETWORK IS SUBJECT TO THE PLAN’S ONGOING COORDINATION.

(c) The Plan will provide you with a list of Transplant Network facilities. It will help to coordinate your referral and access to the facility of your choice. Only facilities that are participating in the Transplant Network at the time of your admission are Transplant Network facilities.

(d) If the Transplant Network is not used, an additional co-payment of $2,500.00 per transplant will apply. All services related to the transplant will be subject to a maximum annual benefit paid of $750,000 for all transplants.

(e) If a Transplant Network facility is used, the Plan will cover the following additional expenses:

1. Travel expenses for the covered person, donor or recipient, and one member of their immediate family, or designated care giver. Only travel to accompany the Covered Person to and from the Transplant Facility is covered.

(f) Benefits for travel expense and lodging are limited to a maximum of $150.00 per day for lodging and meals and $10,000.00 per transplant for lodging, meals, and travel until benefit is exhausted. Further information on the Transplant Network will be provided to you as part of the pre-certification process for a transplant procedure.

(g) When both the recipient and donor are covered by this Plan, each is entitled to benefits.
When only the recipient is covered by the Plan, both the donor and the recipient are entitled to benefits. The donor’s benefits are limited to those not available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any governmental program. Benefits for the donor are charged against the recipient’s coverage under the Plan.

When only the donor is covered by the Plan, the donor is entitled to benefits. The benefits are limited to only those not available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any governmental program. No benefits are provided to the non-covered transplant recipient.

If any organ or tissue is sold rather than donated, no benefits are payable for the purchase or removal of such organ or tissue. Other costs related to the evaluation and procurement are covered for a recipient who is covered under this Plan.
12.3 **PRESCRIPTION DRUG PROGRAM**

Prescription drugs are covered under a prescription drug card program (Program) (refer to section 10.5).

Eligible Employees receive an identification card to be presented to the participating pharmacist at the time the drug is purchased. Through a special arrangement with the participating pharmacies, the pharmacist is reimbursed by the Program, which will bill the Fund. There are contractual arrangements between the Program and pharmacy with regard to the reimbursement amounts.

A Covered Person may use a non-participating pharmacy and submit a claim form to the Program for reimbursement only if no participating pharmacy is located within a 20 road miles of the Covered Person’s residence of record.

The following are covered under the Program:

a) Formulary Prescription drugs;
b) Insulin Syringes;
c) Injectable Insulin;
d) Diabetic Supplies;
e) Allergy Injections;
f) Retin A and Accutane when prescribed for dependents under age 25, or for adults when medically necessary and not cosmetic;
g) Viagra, Cialis, and Levitra; and
h) Drugs for Attention Deficit Disorder (ADD)

The following are excluded from coverage:

a) Non-legend drugs other than insulin;
b) Therapeutic devices or appliances, support garments, and other non-medical substances;
c) Investigational or experimental drugs, including compounded medications for non-FDA approved use;
d) Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation carrier, or any municipal state or federal program;
e) Retin A except when prescribed for dependents under age 25, or for adults when medically necessary and not cosmetic;
f) Rogaine;
g) Dietary pills; and
h) Prescription vitamins other than pre-natal vitamins or children's vitamins for infants up to one year of age

Injectables and specified medications for oral, inhalation, or topical use, other than those listed as covered under the Program, require prior authorization and, when necessary, case management, to be covered. For prior authorization, call Sav-Rx Prescription Services at (800) 228-3108.
13. GENERAL AND SPECIFIC EXCLUSIONS AND LIMITATIONS

No benefits shall be payable for or on account of any of the following:

a) any bodily injury or sickness for which the person on whom claim is presented is not under the regular care of a doctor;

b) any bodily injury or sickness for which the person on whom claim is presented has or had a right to compensation under any Worker's Compensation or occupational disease law;

c) any bodily injury or sickness which arises from or is sustained in the course of any occupation or employment for compensation, profit, or gain, including, but not limited to, conditions covered by the Florida Fire Fighters Heart and Lung Bill, Section 112.18, Florida Statutes, and those conditions covered by Section 112.181, Florida Statutes (High Risk Employees only);

d) any supplies or services (a) for which no charge is made, (b) for which the individual is not required to pay, (c) furnished by or payable under any plan or law or any Federal or State, Dominion or Provincial Government, (d) furnished by a County, Parish, or Municipal hospital when there is no legal requirement to pay for such supplies or services;

e) loss caused by war or any act of war (declared or undeclared) or military service of any country;

f) participating in (a) a felony or attempted felony or (b) a riot, insurrection, or civil commotion;

g) any charges resulting from or occurring (a) during the commission of a crime by the Covered Person or (b) while engaged in an illegal act, illegal occupation, or aggravated assault;

h) any unlawful use or possession of any controlled substance or any harmful chemical substance;

i) charges for tooth extractions, other dental work or surgery that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease, or disease of the gingival tissue, except as provided under Eligible Expenses;

j) charges for eye refractions, the fitting or cost of eyeglasses, hearing aids, or contact lenses, except as provided under Eligible Expenses;

k) charges for cosmetic surgery, which includes but is not limited to: (a) surgery to the upper and lower eyelid; (b) penile implant; (c) augmentation or reduction mammoplasty, except as provided under Eligible Expenses; (d) full or partial face lift; (e) derma or chemo abrasion; (f) scar revision; (g) otoplasty; (h) skin resurfacing; (i) lift, stretch, or reduction of abdomen, buttocks, thighs, or upper arm; (j) silicone injections to any part of the body; and (k) rhinoplasty; except if such treatments or operations are for repair of disfigurement resulting from an accidental injury and such treatment commences within one year after such injury was sustained (unless treatment is delayed due to medical necessity, in which case the time limitation of one year will be extended until treatment can be performed), or unless such treatment or operations are for correction of a congenital anomaly in a dependent child;
l) charges for examinations or tests for check-up purposes and which are not incident and necessary
to treatment of injury or sickness, except as provided under Eligible Expenses;

m) charges incurred in connection with nervous or mental disorders, except as provided under
“Nervous or Mental Disorders”;

n) charges for nursing expense, except as provided under Eligible Expenses;

o) charges for manipulative services, including associated x-rays, diagnostic tests, physical therapy,
and laboratory charges, in excess of $650 per calendar year for panel providers. No such charges
will be paid to non-panel providers;

p) charges in connection with any care or treatment of teeth or the fitting or wearing of dentures; any
care or treatment of teeth or gums; or any care or treatment for procedures involving bones or
joints of the jaw and facial region except as provided under Eligible Expenses in paragraph (w);
however, this exclusion shall not apply to treatment of accidental injury to sound natural teeth
(including their replacement) if the injury occurs while covered and the treatment is given within
six (6) months after the date of injury (unless such treatment is delayed due to medical necessity,
in which case the time limitation of six (6) months will be extended until treatment can be
performed); this exclusion shall also not apply to care or treatment of teeth or gums resulting
from, or due to medically necessary treatment covered by this Plan;

q) charges incurred as a result of narcotism, or other drug addiction, or drug abuse, or complications
thereof, except as otherwise provided in subsection 11.6, or any accidental injury or illness
resulting from the injured person being under the influence of any intoxicant, narcotic, or
barbiturate beyond the legal limit unless administered on the advice of a physician and taken in
accordance with the prescribed dosage or for loss sustained or contracted in consequence of
ingestion or use of hallucinatory drugs. An injured person’s refusal to submit to any breath,
blood, or urine test for alcohol, chemical substances, or controlled substances upon the request
of a law enforcement officer will be deemed an admission and create the presumption that the
injuries or sickness occurred as a result of the person being under the influence of an intoxicant,
narcotic, or barbiturate beyond the legal limit;

r) care and treatment of morbid obesity, weight loss or dietary control whether or not it is in any
case a part of the treatment or another sickness. Medically necessary charges for morbid obesity
(as defined in section 9.38), including laparoscopic and open gastric bypass, laparoscopic gastric
and adjustable lap band surgery, open and laparoscopic bilipancreatic diversion, and the
duodenal switch, or other FDA approved procedures, and the removal of excess skin as a result
of these procedures will be covered, provided (1) The candidate demonstrate a history of
unsuccessful weight loss attempts within the past three years, provide documentation of at least
4 months of consecutive adherence to a professionally supervised weight loss program, progress
notes or physicians notes are required. A summary letter documenting participation is not
sufficient, and (2) The candidate undergoes prescreening (Psychological and/or Psychiatric and
Surgical), and (3) The candidate must undergo physical exam/clearance and must have
established relationship with a licensed Physician who is treating the candidate pre-surgery and
will continue to provide treatment post-surgery, and (4) the surgical provider and facility must
be established and experienced. They should be a designated Surgery Center of Excellence and
have a comprehensive and multidisciplinary obesity surgical program. Additionally excluded are any expenses, services, or treatments for any form of food supplement or augmentation (unless necessary to sustain life in a critically ill person) Expenses for physician-monitored weight loss programs shall not be covered by this Plan;

s) charges incurred as a result of sexual transformation;

t) charges incurred for vision therapy, speech, or occupational therapy, except as provided under Eligible Expenses;

u) charges for services, supplies, or treatment which are of an experimental or investigational nature. These include: (1) care, procedure, treatment protocol or technology which: (a) is not generally accepted as safe, effective, appropriate, and medically necessary for the injury or sickness throughout the recognized medical profession and established medical societies in the United States; or (b) any medical procedure or drug that does not have scientific evidence that permits conclusions as to its effect on health outcomes. Scientific evidence is only evidence that is obtained from well designed and soundly conducted studies. Such studies must have been published in recognized peer review journals. The study must show a measurable effect on health outcomes that can be duplicated outside of the study’s setting. Decisions to cover, or exclude, a treatment will be based on the conclusions of prevailing medical research. If you have a life threatening condition (e.g. likely to cause death within one year), the plan may provide coverage for a treatment that would otherwise be excluded under this provision. The Plan reserves sole discretion to make this determination. Such coverage will only be approved if a treatment is provided under a specific research protocol that meets standards equal to those of the National Institutes of Health and has shown promise in limited use. This exclusion shall not apply to a Full CT Body Scan (with Carotid Artery Ultrasound), as provided for in Section 11.8(c)(28);

The Plan will rely on the Data project of the American Medical Association, the National Institute of Health, the U.S. Food and Drug Administration, The National Cancer Institute, Office of Health Technology Assessment, and Congressional Office of Technology Assessment in determining investigational or experimental services,

v) charges for services in connection with educational, learning, or developmental disabilities;

w) charges for male or female reversal of sterilization, sex change, or implantation with any sex organ;

x) charges incurred due to altering the size or shape of the breast, male or female, whether voluntary or not, except as otherwise provided in this Plan for reduction mammoplasty, reconstructive surgery and prosthetic devices due to mastectomy;

y) charges for foot care solely for improvement of comfort or appearance including but not limited to care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails;

z) charges for private room accommodations in a hospital unless prescribed by a physician for medically necessary isolation purposes due to the existence or suspicion of a contagious disease;
aa) charges for corrective shoes (unless attached to a brace), or other corrective devices or appliances, except as provided under Eligible Expenses;

bb) charges for services rendered by a physician, nurse, or licensed therapist if such physician, nurse, or licensed therapist is a close relative of the Covered Person, or resides in the same household of the Covered Person;

c) charges incurred outside the United States if the Covered Person traveled to such a destination for the sole purpose of obtaining medical services, drugs, or supplies;

d) charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated;

e) charges incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, or charges incurred as a result of or in connection with custodial care, education or training, except if specifically covered under the Plan, or expenses actually incurred by other persons;

f) charges incurred in connection with services and supplies which are not necessary for treatment of the injury or illness, or are in excess of UCR, or are not recommended and approved by a physician, unless specifically shown as a Covered Expense elsewhere in the Plan;

g) charges incurred while confined in a hospital owned or operated by the United States government, or any agency thereof; or charges for services, treatments or supplies furnished by the United States government or any agency thereof, except for non-service related treatments which are then considered for payment by the Plan;

h) charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examination or tests not connected with the actual illness or injury except as provided for in section 10.4, Major Medical Benefits;

i) no benefits are payable for services and supplies as a result of or in connection with an elective abortion except under the circumstances of rape or incest;

j) no benefits are payable for services and supplies to the extent that the benefits would be payable under the terms of any automobile Medical Personal Injury Protection, (PIP) Automobile No-Fault, or Uninsured or Under-insured Motorist insurance coverage, or similar contract of insurance;

k) charges incurred as a result of conditions or complications incident or related to services excluded under the Plan;

l) charges for marriage counseling except as provided through the Employee Assistance Program;

m) charges for hearing exams except when determined to be medically necessary;
nn) physician charges will not be covered for the interpretation of pathology results conducted by PPO Panel providers. Non-PPO panel providers will be covered, where applicable, under section 10.4, Major Medical Benefits;

oo) charges for therapeutic massages by a Physical Therapist, Occupational Therapist or Chiropractor except with a billing code of 97124 and is limited to 15 minutes. Charges for therapeutic massages lasting more than 15 minutes require a review for Medical Necessity.
14. SUBROGATION

RECOVERY RIGHTS

GENERAL RECOVERY RIGHTS PROVISIONS

APPLICABLE TO RIGHT OF SUBROGATION, RIGHT OF REIMBURSEMENT, EXCESS COVERAGE PROVISION AND WORKERS' COMPENSATION

By accepting benefits paid by this plan, you agree to all of the following conditions. The payment of any claims by the plan is an advancement of plan assets. The plan has first priority to receive repayment of those plan assets out of any amount you recover. The plan's recovery rights have first priority over any and all other claims to recover damages, including first priority to receive payment from any liable or responsible party before you receive payment from that party. The plan's recovery rights will apply regardless of whether the amount of health care expense is agreed upon or defined in any settlement or compromise. The plan's recovery rights will apply even if any health care expense is excluded from the settlement or compromise. These rights will apply regardless of whether or not you are made whole.

The plan will not pay attorney fees without the express written consent of the plan administrator. The plan will not pay any costs associated with any claim or lawsuit without the express written consent of the plan administrator.

If you are deceased, the rights and provisions of this section will apply equally to your estate. If you are legally incapacitated the rights and provisions of this section will apply equally to your legal guardian.

In consideration of the coverage provided by this plan, when you file a claim you agree to all of the following conditions. You will sign any documents that the plan considers necessary to enforce its recovery rights. You will do whatever is necessary to enable the plan to exercise its recovery rights. You will follow the provisions of this section and do nothing at any time to prejudice those rights. You will assign to the plan any rights you have for expenses the plan paid on your behalf. You will hold any settlement funds in trust, either in a separate bank account in your name or in your attorney’s trust account, until all plan assets are fully repaid or the plan agrees to disbursement of the funds in writing, if you receive payment from any liable or responsible party and the plan alleges that some or all of those funds are due and owed to the plan. You will serve as a trustee over those funds to the extent of the benefits the plan has paid.

For the purposes of this provision, the following definitions will apply:

1. Health care expense means any medical, dental or loss of time expense that has been paid by the plan. It also includes any medical, dental or loss of time expense that may be payable by the plan in the future.

2. Any responsible or liable party means the responsible or liable party; any liability or other insurance covering the responsible or liable party; you or your covered dependent's own uninsured motorist insurance or under insured motorist insurance; any medical payment, no-fault or school insurance coverage.

You have a duty to cooperate with the plan in the pursuit of any recovery. Failure to comply with the requirements of this section may result in the loss of your benefits under this plan.
Right of Subrogation

If, after payments have been made under this plan, you have a right to recover damages from a responsible or liable party, the plan shall be subrogated to that right to recover. The plan's right of subrogation is to full recovery. It may be made from any responsible or liable party. It will be to the extent of expenses that are paid or payable for any health care expenses under the plan.

Right of Reimbursement

If benefits are paid under this plan and you recover from a responsible or liable party by settlement, judgment or otherwise, the plan has a right to recover from you. Recovery will be in an amount equal to the amount of plan assets paid on your behalf. The plan's right of reimbursement may be from funds received from any responsible or liable party. It will be to the extent of plan assets that are paid or payable for any health care expenses under the plan.

Excess Coverage Provision

Benefits are not payable for an injury or sickness if there is any responsible or liable party providing coverage for health care expenses you incur. This will apply regardless of whether such other coverage is described as primary, excess or contingent. In order to avoid delays in the paying of claims the plan may make payments on your behalf for covered expenses for which there is other insurance providing medical payments or health care expense coverage. Such payments are at the sole discretion of the plan and will be considered an advancement of plan assets to you.

This plan does not provide benefits or may reduce benefits for any present or future covered expenses that you have been compensated for. This will apply to the extent of any recovery by settlement, judgment or otherwise from any responsible or liable party. Benefits may be denied or reduced regardless of whether such recovery or part thereof is specifically denominated for health care expenses, personal injuries, lost wages or any other loss. Any reduction or denial of benefits is at the sole discretion of the plan.

Workers' Compensation

This plan excludes coverage for any injury or sickness that is eligible for benefits under Workers' Compensation. If benefits are paid by the plan and you receive Workers' Compensation for the same incident, the plan has the right to recover. That right is described in this section. The plan reserves its right to exercise its recovery rights against you even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that the injury or sickness was sustained in the course of or resulted from your employment;

3. The amount of Workers' Compensation due to health care expense is not agreed upon or defined by you or the Workers' Compensation carrier; or

4. The health care expense is specifically excluded from the Workers Compensation settlement or compromise.
15. **COORDINATION OF BENEFITS**

15.1 **BENEFITS SUBJECT TO THIS PROVISION**

All Medical Expense Benefits provided under the Palm Beach County Firefighters Employee Benefits Fund are subject to the following provisions and limitations.

15.2 **DEFINITIONS** (for Coordination of Benefits Section only).

a) **Plan.** The term “plan” as used in this section shall mean any plan providing benefits or services for or by reason of medical care or treatment which are provided by: (a) Group Coverage, including all group or group subscriber contracts as well as such group-type contracts as are not available to the general public and can be obtained and maintained only because of the Covered Person's membership in or connection with a particular group or organization; (b) any governmental programs or coverage required or provided by any statute, including Medicare; (c) coverage provided under hospital or medical service plans or other prepayment coverage, provided on a group basis; (d) group labor-management trustees plans, union plans, group association plans, employer organization plans, employee benefit organization plans; or (e) individual liability policies or contracts including “no-fault” automobile insurance. “No-Fault” automobile insurance, as used herein, refers to that coverage as required by the Florida Automobile Reparations Reform Act under which Personal Injury Protection benefits are paid or payable.

b) **This Plan.** The term “This Plan” means the Palm Beach County Firefighters Employee Benefits Fund Plan Document Revised and Restated and Summary Plan Description.

c) **Allowable Expense.** The term “Allowable Expense” means any necessary, reasonable, and customary item of medical expense incurred, a portion of which is covered under one of the plans covering the person for whom claim is made.

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

This Plan shall not be required to determine the existence of any other plan, or the amount of benefits payable under any plan other than This Plan. The payment of benefits under This Plan shall be affected by the benefits payable under other plans only if This Plan is furnished with information concerning the existence of such other plans by the employer, any insurance company, organization, or Covered Person.

d) **Claim Determination Period.** The term "Claim Determination Period" means a period commencing with any January 1, and ending at 12 o'clock midnight on the next succeeding December 31st or that portion of such period during which the person on whose expense claim is based has been covered under This Plan.
15.3 EFFECT ON BENEFITS

a) This provision shall apply in determining the benefits due a person covered under This Plan for any Claim Determination Period if the sum of benefits that would be payable under This Plan in the absence of Coordination of Benefits (C.O.B) and the benefits that would normally be payable under all other plans would exceed 100% of the expenses actually incurred.

b) As to any Claim Determination Period to which this provision is applicable, the benefits that would be payable under This Plan in the absence of C.O.B for the Allowable Expenses incurred shall be reduced to the extent necessary so that the sum of (a) such reduced benefits, and (b) all the benefits paid or payable for such Allowable Expenses under all other plans shall not exceed 100% of such Allowable Expenses.

c) If another plan insuring or covering the person under This Plan contains a similar non-duplication of medical expense benefits provision which coordinates its benefits with those of This Plan, and would determine its benefits after the benefits of This Plan have been determined, then the benefits of such other plan will not be considered for the purposes of determining the benefits due under This Plan.

d) When a claim is submitted in accordance with any group hospital, medical, or surgical expense policy, or in accordance with any group health care service plan, or group-type self-insurance plan, that provides protection, insurance, or indemnity against hospital, medical, or surgical expenses, and the policy or any other document that provides coverage includes a coordination of benefits provision, and the claim involves another policy or plan which has a coordination of benefits provision, the following rules shall be used to determine the order in which benefits under the respective health policies or plans will be determined:

1) The benefits of a policy or plan which covers the person as an employee, member, or subscriber, other than as a dependent, are determined before those of the policy or plan which covers the person as a dependent.

2) Except as stated in paragraph (3) below, if two or more policies or plans cover the same child as a dependent of different parents:

   (a) The benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls earlier in the year are determined before those of a policy or plan of the parent whose birthday, excluding year of birth, falls later in that year; but

   (b) If both parents have the same birthday, the benefits of the policy or plan which covered the parent for a longer period of time are determined before those of the policy or plan which covered the parent for a shorter period of time.

However, if coordinating with an out-of-state policy or plan which contains provisions under which the benefits or a policy or plan which covers a person as a dependent of a male are determined before those of a policy or plan which covers the person as a dependent of a female and if, as a result, the policies or plans do not agree on the order of benefits, the provisions of the other policy or plan shall determine the order of benefits.
Palm Beach County Firefighters Employee Benefits Fund
Plan Document, Revised and Restated and Summary Plan Description
(Effective January 1, 2011)

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

(a) First, the policy or plan of the parent with custody of the child;
(b) Second, the policy or plan of the spouse of the parent with custody of the child; and
(c) Third, the policy or plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and if the entity obliged to pay or provide the benefits or the policy or plan of that parent has actual knowledge of those terms, the benefits of that policy or plan are determined first. This does not apply with respect to any claim determination period or plan or policy year during which any benefits are actually paid or provided before that entity has that actual knowledge.

4) The benefits of a policy or plan which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a policy or plan which covers the person as a laid-off or retired employee or as that employee's dependent. If the other policy or plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this paragraph shall not apply.

5) If none of the rules in paragraphs (a), (b), (c), or (d) determine the order of benefits, the benefits of the policy or plan which covered an employee, member, or subscriber for the longer period of time are determined before those of the policy or plan which covered the person for the shorter period of time.

6) If a person is covered under a COBRA continuation plan and also under another group plan, the benefits of the plan which covers the person as an employee or as the employee’s dependent are determined before those of the plan which covers that person as a former employee, or as the former employee’s dependent according to COBRA.

e) If any plan lacks a coordination of benefits provision, it is the Primary Plan.

15.4 COORDINATION WITH PIP AND/OR "NO-FAULT"

A Covered Person is expected to obtain the minimum amount of liability insurance coverage required by law. Regardless of whether the Covered Person had actually secured such coverage at the time of the accident, sickness, or injury, no benefits will be payable for any claim until the amount of the covered expenses exceeds the minimum limit of insurance benefits that is payable or would have been payable if the legally required insurance coverage had been in effect.

Benefits payable under This Plan shall be secondary to any benefits which are available to a Covered Person under-no-fault insurance and P.I.P. (Personal Injury Protection), regardless of whether the Covered Person actually is covered by such insurance and regardless of whether there is any deductible in effect. The Plan shall pay benefits as if the Covered Person had coverage in effect with no deductible.
15.5 COORDINATION WITH MEDICARE

When a Covered Person is eligible for Medicare, the Plan will coordinate with Medicare as follows:

a) **For Persons Under 65.** If any Covered Person is entitled to Medicare for reasons other than being 65 or older (for example, because of disability or being an End Stage Renal Disease beneficiary), this Plan will usually pay its normal benefits on that person's claims before Medicare pays its benefits unless it is legally permitted to pay second. In cases of End Stage Renal Disease, the Plan will pay primary for the first thirty (30) months and Medicare will be secondary. After the initial thirty (30) months, Medicare will then be primary and the Plan secondary.

b) **For Employees Continuing to Work After Age 65.** If a Covered Employee continues to work for a contributing Employer who has twenty (20) or more employees' after the Covered Person becomes age 65 and eligible for Medicare, he/she is entitled to the same benefits as employees under age 65 as long as he/she meets the regular eligibility rules. This Plan will usually be the primary provider of health care benefits unless it is legally permitted to pay secondary. Medicare will pay secondary benefits only for expenses covered by it and which are not paid by the Plan.

If the dependent spouse of a Covered Employee is age 65 or older and eligible for Medicare while the Covered Employee is still working and eligible under the Plan (regardless of his/her age), this Plan will usually pay its normal benefits for the dependent spouse before Medicare pays unless it is legally permitted to pay second. If the dependent spouse is covered under his/her own Plan, that plan will pay first, this Plan will pay second, and Medicare will pay last.

A Covered Employee (and/or his/her spouse) can decline coverage under this Plan. If they do, Medicare will be their only health care coverage. If a Covered Employee and/or his/her spouse prefers Medicare as their only health care coverage when the Covered Employee is 65, contact the Fund Office (or the dependent spouse should notify his/her own plan). Unless such a choice is made, this Plan will usually continue to pay primary benefits for the Covered Employee (and its normal benefits for his/her spouse) as long as the Covered Employee stays regularly eligible unless it is legally permitted to pay second.

c) **Enrollment in Medicare.** A Covered Employee and his/her spouse are each responsible for enrolling in Medicare Part A and B when eligible to do so. **Enrollment in Medicare Part A and Part B is required for retirees when first eligible to receive Medicare benefits.** A Covered Employee and his/her spouse who is enrolled in Medicare Part A and Part B shall receive a reduced “Medicare rate,” as provided by the Fund.

At present, there is no cost to a Covered Employee for Part A, which provides hospital benefits. Part B covers such items as doctors' services. The government makes a small monthly charge for Part B. If a Covered Employee wants information about Medicare enrollment, they must contact his/her local Social Security office (at least thirty (30) days before their 65th birthday, if possible).

In circumstances where this Plan is a secondary payor, co-pays generally required shall be waived.
15.6 **RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**

For the purposes of enforcing, or determining the applicability of, the terms of this provision of This Plan or any similar provision of any other plan, the Trustees may, without the consent of the Covered Person, release to or obtain from any insurance company, organization, or person any information, with respect to the Covered Person which the Trustees deem to be necessary for such purposes except as may be prohibited by law. Any person claiming benefits under This Plan shall furnish to the Trustees such information as the Trustees determine is necessary under this provision.

15.7 **FACILITY OF PAYMENT**

Whenever payments which should have been made under This Plan are made under any other plan, This Plan shall have the right in its sole discretion to pay to any entity having made such payments any amount the Board shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under This Plan, and, to the extent of such payments, This Plan shall be fully discharged from liability.

15.8 **RIGHT OF RECOVERY**

Whenever payments have been made by This Plan in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, This Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as This Plan shall determine: (1) any persons to, or for, or with respect to, whom such payments were made; or (2) any Insurance Companies or organizations which owe benefits due for such Allowable Expense under any other plan.
16. **RECOVERY FOR MISREPRESENTATION, FRAUD, OR ERROR**

Should benefits be paid by the Plan on behalf of any Covered Person when the basis of such claim is innocently or fraudulently misrepresented, by either the Covered Person or the Medical Provider(s), or if the Benefits are overpaid due to clerical error, or if coverage is provided but premiums not paid, the Plan will have the right to recover all such amounts that have been paid by the Fund or should have been paid by the employer. The Plan shall have the right to recover all Benefits overpaid or premiums underpaid by: (1) a direct recovery from either the Covered Person and/or the Medical Provider(s); (2) by reducing all subsequent Benefits for such Covered Person, or any other covered member of his/her family until such time as the Plan has made full recovery of the amounts due; or (3) by suspending the processing of all claims by or on behalf of the Covered Person until the Covered Person complies fully with this Section, or until the Covered Person provides reasonable assurances, satisfactory in the judgment of the Board of Trustees, that he or she will comply with this Section. Such recovery for any act listed above may also include all collection costs, which includes, but is not limited to the following: medical investigation charges, auditors' fees, and attorneys’ fees, as necessary, whether suit is filed or not, and court costs.

Any person who knowingly and with intent to defraud files a statement of claim or any person who assists in the filing of a statement or claim with false information or conceals for the purpose of misleading information concerning any material fact hereto, commits a fraudulent act that is a crime. In the event that such a claim is submitted by a participant or anyone else, the claim would be denied, the full sanctions under the law would be followed, and the eligibility of such person submitting or being a party to such a fraudulent claim would be suspended for a minimum period of one year with reinstatement subject to review and approval by the Board of Trustees. In the event any claim is paid as a result of such a fraudulent statement or submission, which is determined as fraudulent, the full penalty of the law will be applied, the amount of the claim will be recovered with interest and the Employee’s eligibility for all benefits under the Fund would be indefinitely suspended. Such recovery for any fraudulent act may also include all collection costs, which includes, but is not limited to the following: medical investigation charges, auditors' fees, and attorneys’ fees, as necessary, whether suit is filed or not, and court costs.
17. **CLAIMS REVIEW PROCEDURE**

a) If a claim, a portion of a claim, or a predetermination of benefits is denied or contested by the Plan, the Covered Person will be notified in writing within forty-five (45) days of submitting the claim and given an opportunity for reconsideration.

b) The Explanation of Benefits (EOB) will identify the contested portion of the claim, the reason(s) for contesting the claim, and provide an explanation of the Plan's Claim Review Procedure.

c) If a Covered Person is not satisfied with the disposition of the claim, the Covered Person must complete a written Request for Reconsideration within thirty (30) days mailed to UMR, Inc. (UMR), 333 West Vine Street, Suite 500, Lexington, KY 40507. (A copy of a Request for Reconsideration is provided at the back of the Plan Document.)

d) Upon receipt of a written Request for Reconsideration, the Plan will re-review the claim. The Covered Person will be notified in writing within thirty (30) days of submitting the Request for Reconsideration and, if the claim is denied, will be given an opportunity for appeal.

e) The written denial will give:

   1) specific reason(s) for the denial;
   2) a reference to specific Plan provision(s) on which the denial is based;
   3) a description of any additional material or information necessary to perfect the claim and reasons why such material or information is needed; and
   4) an explanation of the Plan’s Claim Review Procedure.

f) If a claim is not acted upon within forty-five (45) days, the Covered Person may proceed to the review and appeal procedure stage, described below, as if the claim had been denied.

g) Review and Appeal Procedure:

   1) Where a claim has been denied or partly denied, an appeal of the denial may be made, and a subsequent review will be performed. When a Request for Reconsideration is first received by Claims Administrator they will contact the Benefits Administrator.

   2) Within thirty (30) days after receipt of written notice that the Request for Reconsideration has been denied, the Covered Person or his/her designated representative may make a written request for review by submitting a completed Claim Appeal Form (a copy of which is provided at the back of the Plan Document) to:

   **THE BOARD OF TRUSTEES OF PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND**  
   2328 S. Congress, Suite 2C  
   West Palm Beach, Florida 33406
3) The Covered Person or his/her designated representative may review pertinent documents relating to the denial and may submit issues and comments in writing.

h) Decision on Review: Within sixty (60) days of the request for review, the Trustees shall make determination of claims by providing a full and fair review of the denied claim in accordance with the provisions of the Plan. A decision will be made within one-hundred twenty (120) days after receipt of the initial claim. The decision on review will be in writing and will include specific reasons for the decision. The Covered Person or his/her designated representative has a right to be present at the Board Meeting when the appeal is reviewed.

i) “Federal External Review Program”
The departments of Health and Human Services, Labor and Treasury (Departments) will establish a Federal external review (appeal) process which will be available in those jurisdictions where no State external review (appeal) process is in effect. Where applicable, once the process has been established by the Departments, you will be provided with additional information concerning the process. Contact UMR at the telephone number shown on your ID card for more information on the Federal external review (appeal) program.

18. COVERAGE AFTER TERMINATION OF MAJOR MEDICAL PLAN

If injury is sustained or sickness (including pregnancy) commences while the coverage is in force, benefits otherwise payable will be paid for any expenses incurred after the termination of the Plan if from the date such expenses are incurred the Covered Person is totally and continuously disabled by reason of such injury or sickness. Such benefits shall be payable for only expenses resulting from and relating to such disability and only during the uninterrupted continuance of said disability condition, but not to exceed a period of twelve (12) months from the date the Plan was discontinued. Benefits payable after the Calendar Year in which coverage terminated are subject to a new Deductible Amount.

For the purpose of this provision, an Employee is totally disabled only if under a physician's care and completely prevented by a sickness or injury from engaging in any occupation for which he/she is, or becomes qualified by reason of education, training, or experience, while a dependent must be prevented from carrying on normal activities of a person of like age, sex, education, training, or experience. In addition, a person who was actively employed immediately prior to his/her disability is not totally disabled unless completely prevented from engaging in any work for compensation or profit.

Benefits payable under this provision shall cease on the earliest of:

a) Twelve (12) continuous months from date the Plan terminates coverage;

b) The date the Covered Person is no longer totally and continuously disabled; or

c) The date the Covered Person becomes eligible for coverage under another Group Insurance Program.
19. EXTENSIONS OF COVERAGE

Depending on when you leave employment with Palm Beach County Fire Rescue, the Plan may provide continued coverage for you and your family. You will be required to pay premiums for this continued coverage.

19.1 YOUR LEGAL RIGHTS TO CONTINUATION COVERAGE UNDER FEDERAL LAW

Under a federal law similar to COBRA (Consolidated Omnibus Budget Reconciliation Act), the Fund is required to offer Covered Employees and their Covered spouses and dependents the opportunity to extend coverage temporarily at group rates after coverage under This Plan would otherwise cease. This extension will be referred to as “Continuation Coverage.” Evidence of your good health is not required for this extension.

A. As an employee covered under This Plan, you have the right to elect Continuation Coverage if you lose your coverage (or your premium payments or contributions for coverage increase) because:

1) your hours of employment are reduced; or
2) your employment is terminated for reason other than gross misconduct.

B. Your spouse may elect Continuation Coverage, if he or she loses coverage or premium payments or contributions for coverage increase, under This Plan because:

1) your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
2) you die;
3) you divorce or are legally separated; or
4) you become entitled to Medicare (Part A or B).

C. Your dependent child may elect Continuation Coverage, if he or she loses coverage or premium payments or contributions for coverage increase, under This Plan because:

1) he or she loses dependent status under This Plan;
2) your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
3) you die;
4) you and your spouse divorce or are legally separated; or
5) you become entitled to Medicare (Part A or B).

A child born to or placed for adoption with the Covered Employee during the Continuation Coverage period is also entitled to elect Continuation Coverage. Such a child’s coverage period will be determined according to the date of the qualifying event that gave rise to the Covered Employee’s coverage.
D. By law, to be eligible for Continuation Coverage, you (or your spouse or dependent child, if applicable) must notify the Claims Administrator within sixty (60) days after:

1) you and your spouse are divorced or legally separated; or
2) one of your children loses his or her dependent status under This Plan.

You (or your spouse or dependent child, if applicable) will then be notified by certified mail of your right to elect Continuation Coverage and the cost to do so. The deadline for electing Continuation Coverage is sixty (60) days after the date This Plan ceases to cover you or from the date you are notified or could have been notified by certified return receipt mail, whichever is later.

If you (or your spouse or dependent child, if applicable) choose Continuation Coverage, This Plan will provide coverage identical to that available to similarly situated active employees, including the opportunity to choose among health plan options available during an open enrollment. However, you (or your spouse or dependent child, if applicable) must pay the full cost of this coverage plus an administrative charge.

If a Covered Employee or spouse of a Covered Employee elects Continuation Coverage without specifying whether the election is for self-only coverage, the election will be considered to be on behalf of all other qualified beneficiaries with respect to that qualifying event.

If the original qualifying event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or loss of dependent status of a dependent child under This Plan, then each qualified beneficiary will have the opportunity to elect thirty-six (36) months of Continuation Coverage from the date of the qualifying event. If you (or your spouse or dependent child, if applicable) lose coverage under This Plan because your employment was terminated (other than for gross misconduct) or your hours of employment were reduced (even if the reduction in hours is immediately followed by termination of employment), then the maximum continuation period will be eighteen (18) months from the date of the qualifying event. If, during those eighteen (18) months, another qualifying event takes place that entitles you (or your spouse or dependent child, if applicable) to Continuation Coverage, your Continuation Coverage (or your spouse’s or dependent child’s Continuation Coverage, if applicable) may be extended by another eighteen (18) months. However, in no event will your Continuation Coverage (or your spouse’s or dependent child’s Continuation Coverage, if applicable) extend for more than a total of thirty-six (36) months from the date of the initial event.

E. Disability is a special issue. If the Social Security Administration determines that you (or your spouse or dependent child, if applicable) are disabled during the first sixty (60) days of the Continuation Coverage period, or, in the case of a child born to or placed for adoption with a Covered Employee during a Continuation Coverage period, during the first sixty (60) days after a child’s birth or placement for adoption, then your Continuation Coverage period as well as your spouse’s and any dependent’s Continuation Coverage periods may be extended from eighteen (18) months to twenty-nine (29) months. To qualify, you (or your spouse or dependent child, if applicable) must notify This Plan’s Claim Administrator within sixty (60)
days of the date of the Social Security determination and during the initial eighteenth (18)-
month Continuation Coverage period. If there is a final determination that the qualified
beneficiary is no longer disabled, This Plan’s Claim Administrator must be notified within
thirty (30) days of the determination by the qualified beneficiary, and any coverage that extends
beyond the maximum original eighteenth (18)-month coverage will be terminated for all
qualified beneficiaries.

Your right to Continuation Coverage (or your spouse’s or dependent child’s right, if applicable)
by law ends if:

1) the Fund ceases to provide group health coverage;
2) you (or your spouse or dependent child, if applicable) fail to pay the premium within
   thirty (30) days after its monthly due date;
3) you (or your spouse or dependent child, if applicable) become covered, after the date
   of your Continuation Coverage election, under another group health plan, including
   a governmental plan but not a plan maintained by the same employer who sponsors
   the Continuation Coverage, that does not contain an exclusion or limitation with
   respect to any pre-existing condition that applies to you or that you have not satisfied;
4) you (or your spouse or dependent child, if applicable) become entitled to Medicare
   after the date of the Continuation Coverage election;
5) you (or your spouse or dependent child, if applicable) have extended Continuation
   Coverage due to a disability and then you are determined by the Social Security
   Administration to be no longer disabled;
6) the maximum required Continuation Coverage period expires; or
7) your coverage is terminated for cause, such as for fraudulent claim submission, just
   as coverage for similarly situated active employees would be terminated for similar
   reasons,
8) you (or your spouse, if applicable) notifies This Plan’s Claims Administrator of your
   wish to cancel Continuation Coverage.

F. Continuation of coverage for employees placed on Administrative Leave without pay may
continue until such time that the employer returns to pay status, employee
retires or employment is terminated. The employee may continue coverage until the grievance
process has been completed; all other provisions such as premium amounts, due dates and
eligibilities remain constant.

There is no right of reinstatement after termination of Continuation Coverage. Continuation
Coverage shall immediately terminate without notice of the first day of the month following
any of the above-described events. Full premiums for Continuation Coverage must be paid
until Continuation Coverage terminates.
19.2 **PREMIUM COST**

a) **Premium Amount** - The amount of the premium shall be determined actuarially by the Board of Trustees, which amount shall be reviewed, and may be adjusted, from time to time. The premium cost may vary if the Fund provides dental or vision benefits, or if continuation coverage is provided due to a disability.

b) **Monthly Installments** - The premium for COBRA continuation coverage shall be paid monthly.

19.3 **PREMIUM DUE DATES**

a) **Timely Payment Required** - Except for the first month of continuation coverage, payment is due at the Claims Administrator by the first day of each month for which a premium is due.

b) **First Payment** - The first payment for the first month of continuation coverage must be paid no later than forty-five (45) days after the date on which the Qualified Beneficiary elected continuation coverage. All payments due by the first month of insurance coverage must also be paid with the first premium payment.

c) **Grace Period** - The Fund provides a thirty (30) day grace period following the due date. This grace period does not apply to the first payment but only to monthly payments thereafter. Any payment made after the grace period ends will not be timely and will result in termination of continuation coverage as of the last day of the month for which the premium was paid on a timely basis. If continuation coverage ends, coverage cannot be reinstated.

19.4 **YOUR ENTITLEMENT TO CONTINUATION COVERAGE AS A RETIREE**

Under Florida law, the Fund is required to offer retirees, and their eligible dependents, the opportunity to continue coverage at rates of no more than the premium cost applicable to active employees. This extension will be referred to as “Retiree Continuation Coverage.”

A. As a retiree covered under this Plan, you have the right to elect Retiree Continuation Coverage if you lose your coverage because:

1) your employment is terminated because you reached the normal age for retirement, and you have retired; or
2) you have retired due to a disability; or
3) you are otherwise considered retired, as defined by applicable law.

B. Your eligible Dependents may elect Retiree Continuation Coverage, if he or she loses coverage because:

1) your employment is terminated because you reached the normal age for retiring, and you have retired; or
2) you have retired due to a disability; or

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In order for you and, if applicable, your eligible dependents, to be eligible for Retiree Continuation Coverage, you must notify the Claims Administrator within sixty (60) days before:

1) your employment is terminated because you reached the normal age for retirement, and you have retired; or
2) you have retired due to a disability; or
3) you are otherwise considered retired, as defined by applicable law.

You (or your spouse or dependent child, if applicable) will then be notified of your right to elect Retiree Continuation Coverage and the cost to do so. The deadline for electing Retiree Continuation Coverage is thirty (30) days after the date This Plan ceases to cover you as an active employee or from the date you are notified, whichever is later.

If you (or your spouse or dependent child, if applicable) choose Retiree Continuation Coverage, This Plan will provide the same health and hospitalization insurance coverage as is available to active employees, which includes the opportunity to choose among health plan options available during an open enrollment.

If a Covered Employee or spouse of a Covered Employee elect Retiree Continuation Coverage without specifying whether the election is for self-only coverage, the election will be considered to be on behalf of all other eligible dependents.

Your entitlement to Retiree Continuation Coverage (or your spouse’s or dependent child), if applicable, ends if:

1) the Fund ceases to provide group health coverage;
2) you (or your spouse or dependent child, if applicable) fail to pay the premium within thirty (30) days after its monthly due date;
3) your coverage is terminated for cause, such as for fraudulent claim submission, just as coverage for similarly situated active employees would be terminated for similar reasons;
4) you (or your spouse, if applicable) notify This Plan’s Claims Administrator of your wish to cancel Retiree Continuation Coverage.

There is no right of reinstatement after termination of Retiree Continuation Coverage. Retiree Continuation Coverage shall immediately terminate without notice of the first day of the month following any of the above-described events. Full premiums for Retiree Continuation Coverage must be paid until Retiree Continuation Coverage terminates.
19.5 PREMIUM COST

a) Premium Amount - The amount of the premium shall be no more than the premium offered to similarly situated active employees.

b) Instalments - The premium for Retiree Continuation Coverage shall be paid monthly through the Florida Retirement System Insurance Payroll Deduction Authorization Form; monthly or annually in one lump sum through the Electronic Funds Transfer Authorization Agreement found in the Retiree Continuation Coverage for Medical Benefits packet. A retiree may also pay premiums for Retiree Continuation Coverage by check, provided the check reflects an amount equal to a lump sum annual payment for said coverage.

19.6 PREMIUM DUE DATES

a) Timely Payment Required - Except for the first month of Retiree Continuation Coverage, payment is due at the Fund Office by the first day of each month for which a premium is due.

b) First Payment - The first payment for the first month of Retiree Continuation Coverage must be paid no later than thirty (30) days after the date on which the retiree elected Retiree Continuation Coverage pursuant to the Retiree Continuation Coverage for Medical Benefits packet. All payments due by the first month of insurance coverage must also be paid with the first premium payment.

c) Grace Period - The Fund provides a thirty (30) day grace period following the due date. This grace period does not apply to the first payment but only to monthly payments thereafter. Any payment made after the grace period ends will not be timely and will result in termination of Retiree Continuation Coverage as of the last day of the month for which the premium was paid on a timely basis. If Retiree Continuation Coverage ends, coverage cannot be reinstated.
20. **GENERAL PROVISIONS**

**Effective Date of the Plan** - The effective date of the Plan is November 1, 1984, amended, revised, and restated effective January 1, 2011.

**Plan Year (Benefit Year)** - For purposes of this Document the Plan Year (Benefit Year) runs from January 1 through December 31.

**Clerical Error** - Clerical Error shall not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

**Worker's Compensation Not Affected** - This Plan does not replace or affect any requirement for Worker's Compensation Insurance.

**Time Effective** - The effective time with respect to any dates used in the Plan or any Amendment hereto shall be 12:01 a.m., Eastern Time.

**Pronouns** - Masculine Pronouns used herein apply to both men and women.

**Payment of Claims** - All or a portion of any Medical Expense Benefits covered by the Plan including hospital, nursing, medical, or surgical services may be paid directly to the provider of such service, unless the Covered Person requests otherwise in writing not later than the filing of a proof of claim for such expense. A Covered Person shall be eligible for claims provided that the Covered Person resides in the United States or its territories on the date of loss or date of service.

**Proof of Claim** - Written proof of claim must be furnished to the Plan within one (1) year of the date of loss. Failure to provide such notice will invalidate any claim unless it shall be proven to the satisfaction of the Trustees that it was not reasonably possible to furnish such notice or proof within the time limits provided. Any claim under review by a professional bill review company over one (1) year shall not be subject to this provision.

**Time of Payment of Claims** - After receiving proper written proof of claim, the Plan will promptly pay all benefits then due for Eligible Expenses upon receipt of all information and/or materials required to permit payment of same.

**Benefits at Death** - Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed in the Plan and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Covered Person. Any accrued indemnities unpaid at the Covered Person's death may, at the option of the Plan, be paid either to such beneficiary or to such estate.

**Physical Examination and Autopsy** - The Plan shall have the right to examine the person of any individual whose injury or sickness is the basis of claim, when and as often as it may reasonably require during the pendency of a claim hereunder, and to make an autopsy in case of death, not prohibited by law.

**Bill Review** - The Plan shall have the right to examine or hire a professional to examine any claim for irregular, illegal, or otherwise improper charges to the Covered Person as the result of charges which should be included in the allowance for surgery but are charged separately;
Palm Beach County Firefighters Employee Benefits Fund
Plan Document, Revised and Restated and Summary Plan Description
(Effective January 1, 2011)

chances that should be included in the procedure but are additionally charged to the Covered Person; charges that should be included in the overall level of care but are charged separately; charges to the Covered Person for items that are considered non-disposable hospital or hardware items; billing errors; charges which are placed on the bill but not ordered by the physician, nurse practitioner, or physician assistant; charges which may not represent the “usual or customary price” for a supply or drug, service, surgery, surgical procedure; or the like. The Plan may engage that professional to assist in communicating and negotiating with providers for a reduction in billed charges based on the aforementioned criteria.

Legal Actions - No legal action may be brought to recover on the Plan before completing the requirements of the Claim Denial and Appeal Procedures established by the Board of Trustees.

Change of Beneficiary - The right to change a beneficiary is reserved to the Covered Employee, and the consent of the beneficiary or beneficiaries shall not be required.

Invalidity of Certain Provisions Does Not Invalidate All - If any provision(s) of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision(s) hereof, and this Plan shall be construed and enforced as if such provisions had not been included.

Plan Amendments - The Plan Document may be amended from time to time by the Board of Trustees of the Palm Beach County Firefighters Employee Benefits Fund, in their sole discretion.

Termination of the Plan - The Plan may be terminated at any time by action of the Board of Trustees. Notice of such termination shall be given in writing to all persons who have an interest in the Plan. All claims which have not been submitted at the date of termination but which would have been paid had the Plan continued, will be paid in accordance with all the provisions of the Plan at the time of termination, except that there is no liability on the Board of Trustees or any individual or entity to provide payments over and beyond the amounts available in the Trust for such purposes, except as may be required by law.

21. STANDARDS OF PROOF

The Board of Trustees shall be the sole judge of the standards of proof required in any case. In the application and interpretation of the Plan Document, the decisions of the Board of Trustees shall be final and binding on the Participants and Beneficiaries, the Employer, the Union, and all other persons. Subject to the stated purposes of the Trust Fund and the provisions of the Plan Document, the Board of Trustees shall have the full and exclusive power and authority, in its sole discretion, to determine all questions of coverage and eligibility for benefits, methods of providing or arranging for benefits and all other related matters. The Board of Trustees shall have the full power and authority, in its sole discretion, to construe and interpret the provisions and terms of the Plan Document and all other written documents. Any such determination and any such construction adopted by the Board of Trustees in good faith shall be binding upon all the participants and their beneficiaries.
Palm Beach County Firefighters Employee Benefits Fund  
Plan Document, Revised and Restated and Summary Plan Description  
(Effective January 1, 2011)

PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND  
REQUEST FOR RECONSIDERATION

If you are not satisfied with the disposition of a claim, you or your representative may make a written Request for Reconsideration using this approved form. Please complete this form and mail within thirty (30) days with all documentation not previously provided that may support your claim to: UMR, Inc. (UMR), Attn: Palm Beach County Firefighters Employees’ Claims Appeal, 333 West Vine Street, Suite 500, Lexington, KY 40507. UMR, Inc. (UMR), will make a decision within thirty (30) days of receiving this Request and will notify you in writing with the specific reasons for the decision. If, after completion of this initial review, your claim remains denied in whole or in part, you or your representative have the right to submit an appeal in accordance with Section 17 of your Plan Document using the approved “Claim Appeal Form” contained in your Plan Document.

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<td>Name of Patient (if different):</td>
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<td>ID Number:</td>
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<tr>
<td>Date of Illness or Injury:</td>
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<td>Nature of Illness or Injury:</td>
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Please explain why this claim should be reconsidered (attach additional sheets if necessary):

________________________________________________________________________

Signature of person requesting reconsideration ___________________________ Date __________

(01/01/2010)
PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND
CLAIM APPEAL FORM

If, after submitting a written Request for Reconsideration to UMR, Inc. (UMR), your claim remains denied in whole or in part, you or your representative have the right to submit a written appeal, using this approved form, to the Board of Trustees within thirty (30) days after your claim is denied. Please complete this form and mail with all documentation not previously provided that may support your claim to: The Board of Trustees, Palm Beach County Firefighters Employee Benefits Fund, 2328 S. Congress, Suite 2C, West Palm Beach, Florida 33406. The Board will make a decision within sixty (60) days of receiving this appeal and will notify you in writing with the specific reasons for the decision.

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<td>Please explain why this claim should be reconsidered (attach additional sheets if necessary):</td>
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<td>Signature of person requesting Appeal: __________________________ Date: ______________</td>
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Tracking information: (For Board use only)

Date Appeal received by the Board of Trustees: ________________________________

Action by the Board of Trustees: [ ] granted [ ] denied ________________________________

(01/01/07)
Palm Beach County Firefighters Employee Benefits Fund

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the medical information practices of the Palm Beach County Firefighters Employee Benefits Fund (the “Plan” or “Fund”), as well as the practices of the Plan’s third party administrators (UMR, Inc. (UMR) for medical and dental claims, and Sav-Rx Prescription Services for prescription drugs) that assist in the administration of claims. All of the provisions in this Notice are effective as of June 24, 2003.

Please review this notice carefully. If you have any questions about this notice, please contact the Benefits Administrator at (561) 969-6663.

The Plan understands that medical information about you and your dependents is personal. The Plan is committed to protecting the privacy of medical information relating to you and your dependents. The Plan will not disclose health information without an authorization unless it is necessary to provide health benefits, administer the benefit plan, or as otherwise required or permitted by law. The Plan will make sure that access to your health information is restricted to the Fund personnel who need the information to conduct business. Plan personnel have been trained on policies and procedures to protect your privacy.

Under Federal law, the Plan is required to take reasonable steps to ensure the privacy of your Protected Health Information (PHI). PHI includes all individually identifiable health information which is transmitted or maintained by the Plan, whether the information is transmitted or maintained orally, electronically, or in written form.

This Notice will let you know the following:

1. How we use and disclose your PHI;
2. What your privacy rights are with respect to your PHI;
3. What the Plan’s duties are with respect to your PHI;
4. When and how to file a complaint with the Plan, and with the Secretary of the U.S. Department of Health and Human Services; and
5. Who to contact for further information about the Plan’s privacy policies and practices.

1. How the Plan Uses and Discloses your PHI

The Plan and/or its Business Associates may use or disclose your PHI without your authorization in the following circumstances:

a. Treatment. Treatment is defined as the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. We may disclose your PHI to your health care provider (for example, your doctor or a hospital in which you are staying), so that the provider can coordinate, provide or manage your health care and related services. For example, we may provide the hospital where you are staying with the name of a doctor who has treated you in the past, so that the hospital can contact your doctor with questions about that treatment.
b. Payment. The term payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, and utilization review and preauthorizations). We may use and disclose your PHI to determine and fulfill our responsibility to provide your health plan benefits. For example, we may tell your physician whether or not you are eligible for coverage, at what percentage your benefits will be paid under the Plan, or to coordinate payment with another plan under which you are covered.

c. Health Care Operations. Health care operations include, but are not limited to, customer service activities, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts or health benefits. Health care operations also include disease management, case management, conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse compliance programs, business planning and development, including cost management and formulary development, business management and general administrative activities, including resolution of appeals. For example, we may use information about your claims to project future benefit costs and premiums for participants, to audit the accuracy of claims processing functions, to negotiate discounts for case management functions, or to decide claim appeals.

d. To The Plan Sponsor. We may disclose PHI regarding your participation in the health plan for purposes such as payroll deductions.

e. Enrolled Dependents and Family Members. We will mail explanation of benefits forms and other mailings containing PHI to the address we have on record.

f. As Required By Law. We will disclose medical information about you when we are required to do so by federal, state, or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

g. Workers’ Compensation. We may disclose your PHI when necessary to comply with Workers’ Compensation laws.

h. Public Health. Your PHI may be used or disclosed for public health activities, such as assisting public health authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

i. Decedents. PHI may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

j. Organ/Tissue Donation. Your PHI may be used or disclosed for cadaveric organ, eye, or tissue donation purposes.

k. Health & Safety. Your PHI may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

l. Government functions. Your PHI may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed forces.

Except as described above, no disclosure or use of PHI will be made without your prior written authorization and consent, except to the extent This Plan has taken action in reliance on such authorization. Furthermore, you may revoke your authorization or consent at any time.
2. Your Privacy Rights with Respect to your PHI

You have rights regarding your PHI that the Plan maintains. These rights include:

a. The Right to Request Additional Restrictions. You may ask the Plan to restrict uses and disclosures of your PHI for the purposes of treatment, payment and health care operations described above. We will consider all requests for restrictions carefully; however, we are not required to agree to a requested restriction, unless it relates to disclosures to a health plan for payment and/or health care operations, and the PHI related to a health care service or product for which you have paid in full and out of your own pocket.

b. Right to Receive Confidential Communications. You may ask to receive communications of your PHI from the Plan, by alternate means of communications or at an alternate address. We will consider all requests for alternate communications carefully; however, we are not required to agree to all requests.

c. Right to Inspect and Copy Your Confidential Information. You may ask to inspect or obtain a copy of your PHI, if it is included in certain records maintained by the Plan. There may, however, be times when we will have to deny you access to certain portions of your records. We also may charge you a fee to cover the costs of copying and mailing your records.

d. Right to Amend Your Records. You have the right to ask the Plan to amend your PHI that is maintained in our records. If we determine that our record is incorrect, and if the law allows us to change it, we will change it. However, if your doctor or another person created the information that you want to change, you should ask that person to amend the information.

e. Right to Receive Paper Copy of Privacy Notice. You have the right to receive a paper copy of the health Plan’s Privacy Notice, even if you had previously agreed to receive the Notice electronically. To receive a paper copy of the Plan’s Privacy Notice, please contact the Benefits Administrator at (561) 969-6663.

f. Right to Receive an Accounting of Disclosures. You have the right to receive an accounting of any disclosures we have made of your PHI. This accounting will not include any disclosures made before April 14, 2003; any disclosures made for treatment, payment, or health care operations; any disclosures made earlier than six (6) years before the date of your request; and certain other disclosures that are excepted by law.

If you request an accounting more than once during any 12-month period, we may charge you a reasonable fee for each accounting statement after the first one.

3. The Plan’s Duties with Respect to your PHI

The Plan is required by law to maintain the privacy of your PHI, and to provide you with a notice of our legal duties and privacy practices.

This Notice is effective beginning June 24, 2003, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices, and to apply the changes to any PHI received or maintained by the Plan, even if received by the Plan prior to the change. If a privacy practice is changed, we will notify all participants for whom the Plan still maintains PHI, via a notice in the ‘Backdraft’ newsletter and a notice posted on
the Union’s website, IAFF2928.com. Such notice will be given within 60 days of the effective date of any material change to the Plan’s privacy procedures.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will endeavor not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, this “minimum necessary” standard will not apply in the following situations: uses or disclosures made to the individual patient; disclosures made to the Secretary of the U.S. Department of Health and Human Services; uses or disclosures that are required by law; and uses or disclosures that are required for the Plan’s compliance with legal regulations.

4. **When and How to File a Complaint with the Plan or the HHS Secretary**

If you believe that your privacy rights have been violated, you may file a complaint with the Plan, or with the Secretary of the United States Department of Health and Human Services.

To file a complaint with the Plan, contact the Benefits Administrator at 2328 South Congress Avenue, Suite 2C, West Palm Beach, FL 33406. The telephone number is: (561) 969-6663. You may also file your complaint via e-mail at masedgwick@IAFF2928.com.

To file a complaint with the Secretary of HHS, write to: Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

All complaints must be made in writing. You will not be penalized for filing a complaint.

5. **Who to Contact for Further Information about the Plan’s Privacy Policies and Practices**

If you have any questions about this notice or about any of the subjects addressed in it, please contact the Benefits Administrator, 2328 South Congress Avenue, Suite 2C, West Palm Beach, FL 33406. The telephone number is: (561) 969-6663. You may also address your questions via e-mail to masedgwick@IAFF2928.com.

**Conclusion**

The use and disclosure of Protected Health Information is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), a part of the American Recovery and Reinvestment Act (ARRA), Title XIII of Division A and Title IV of Division B of ARRA, Pub. L. No. 111-5 (February 17, 2009). You may find the HIPAA regulations at 45 Code of Federal Regulations Parts 160 and 164. This notice is a brief summary of the federal regulations. The regulations will control if there is any discrepancy between the information contained in this Notice and the regulations themselves.
STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NMHPA)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

STATEMENT OF RIGHTS UNDER THE WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain entitlements and benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided, in a manner determined in consultation with the attending physician and the patient, for:

1) All stages of reconstruction of the breast on which the mastectomy was performed;
2) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3) Prostheses; and
4) Treatment of physical complications at all stages of the mastectomy, including lymphedema.

These benefits will be provided subject only to deductibles and coinsurance limitations consistent with those established for other medical and surgical benefits provided under this plan. Therefore, you should refer to Section 10 and Section 11 of your Plan Document.

If you would like more information on WHCRA benefits, call UMR, Inc. (UMR) at (877) 210-1840.
APPENDIX

1) Required Notices on Patient Protection and Affordable Care Act (Health Care Reform)
2) Additional Services Covered Under Preventative Benefits
3) CHIP Notice
Patient Protection and Affordable Care Act (Health Care Reform)

Required Notices

Lifetime Limits

The lifetime limit on the dollar value of benefits under the Palm Beach County Firefighters Employee Benefits Fund no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact Michael Sedgwick, Benefits Administrator at 561-969-6663.

Grandfathered Health Plans

The Palm Beach County Firefighters Employee Benefits Fund believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the benefits administrator at 561-969-6663.

The Palm Beach County Firefighters Employee Benefits Fund has elected to not enforce its rights under the Grandfathered Status, and has adopted all changes required of health plans to meet the requirements of the Patient Protection and Affordable Care Act.

Extension of Coverage for Adult Children

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in The Palm Beach County Firefighters Employee Benefits Fund. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to January 1, 2011. For more information contact the Benefits Administrator at 561-960-6663.
The following is a list of all services that are mandated by Health Care Reform legislation to be covered by our plan under Preventive Benefits. When delivered by a network provider, there is no cost sharing for these services.

**All members:**
Yearly preventive medicine visits (Wellness exams)(Non-Fire Rescue Participants Only)
All standard immunizations recommended by the American Committee on Immunization Practices

**Screening/services for all members at appropriate ages:**
Colorectal cancer screening (fecal occult blood testing, sigmoidoscopy, colonoscopy)
Elevated cholesterol and lipids
Certain sexually transmitted diseases and HIV (includes counseling)
Alcohol and substance abuse, tobacco use, obesity, diet and nutrition counseling
High blood pressure
Diabetes
Depression

**For women:**
Screening mammography for women age 50 – 74
Counseling for genetic testing for BRCA breast cancer gene
Screening for cervical cancer including Pap smears
Screening for gonorrhea, Chlamydia, syphilis
Screening for pregnant women for anemia and iron deficiency, bacteriuria, hepatitis B virus, Rh incompatibility
  Instructions to promote and help with breast feeding
Screening for osteoporosis for those age 65 or older
Counseling for those at high risk for breast cancer for chemoprevention

**For men:**
Screening for prostate cancer for those 75 and older
Screening for abdominal aortic aneurysm for those ages 65 to 75

**For Children:**
Screening newborns for hearing, thyroid disease, phenylketonuria, sickle cell anemia
Standard metabolic screening panel for inherited enzyme deficiency diseases
Screening for major depressive disorders
Screening for developmental/autism
Screening for lead and tuberculosis
Fluoride for prevention of dental cavities
Counseling for obesity
Medicaid and the Children’s Health Insurance Program (CHIP)  
Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of November 3, 2010. You should contact your State for further information on eligibility –

**ALABAMA – Medicaid**  
Website: http://www.medicaid.alabama.gov  
Phone: 1-800-362-1504

**ALASKA – Medicaid**  
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/  
Phone (Outside of Anchorage): 1-888-318-8890  
Phone (Anchorage): 907-269-6529

**ARIZONA – CHIP**  
Website: http://www.azahcccs.gov/applicants/default.aspx  
Phone (In state): 1-877-764-5437

**ARKANSAS – CHIP**  
Website: http://www.arkidsfirst.com/  
Phone: 1-888-474-8275

**CALIFORNIA – Medicaid**  
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx  
Phone: 1-866-298-8443

**COLORADO – Medicaid and CHIP**  
Medicaid Website: http://www.colorado.gov/  
Medicaid Phone (In state): 1-800-866-3513  
Medicaid Phone (Out of state): 1-800-221-3943  
CHIP Website: http://www.CHPplus.org  
CHIP Phone: 303-866-3243

**FLORIDA – Medicaid**  
Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml  
Phone: 1-866-762-2237

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Palm Beach County Firefighters Employee Benefits Fund  
Plan Document, Revised and Restated and Summary Plan Description  
(Effective January 1, 2011)
GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP
Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid
Website: http://www.in.gov/fssa/2408.htm
Phone: 1-877-438-4479

KANSAS – Medicaid
Website: https://www.khpa.ks.gov
Phone: 800-766-9012

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-342-6207

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/oms/
Phone: 1-800-321-5557

MASSACHUSETTS – Medicaid and CHIP
Medicaid & CHIP Website: http://www.mass.gov/MassHealth
Medicaid & CHIP Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone (Outside of Twin City area): 800-657-3739
Phone (Twin City area): 651-431-2670

MONTANA – Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Telephone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-877-255-3092

NEVADA – Medicaid and CHIP
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900
CHIP Website: http://www.nevadacheckup.nv.org/
CHIP Phone: 1-877-543-7669

NEW HAMPSHIRE – Medicaid
Website: www.dhhs.nh.gov/ombp/index.htm
Phone: 603-271-4238

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-800-356-1561
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW MEXICO – Medicaid and CHIP
Medicaid Website: http://www.hsd.state.nm.us/mad/index.html
CHIP Website: http://www.hsd.state.nm.us/mad/index.html
Click on Insure New Mexico
CHIP Phone: 1-888-997-2583

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm
Phone: 573-751-6944

NORTH CAROLINA – Medicaid
Website: http://www.nc.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

UTAH – Medicaid
Website: http://health.utah.gov/medicaid/
Phone: 1-866-435-7414

OKLAHOMA – Medicaid
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

VERMONT – Medicaid
Website: http://ovha.vermont.gov/
Telephone: 1-800-250-8427

OREGON – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov
Medicaid & CHIP Phone: 1-877-314-5678

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.famis.org/
CHIP Phone: 1-866-873-2647

PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm
Phone: 1-800-644-7730

WASHINGTON – Medicaid
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-800-562-3022 ext. 15473

RHODE ISLAND – Medicaid
Website: www.dhs.ri.gov
Phone: 401-462-5300

WEST VIRGINIA – Medicaid
Website: http://www.wvrecovery.com/hipp.htm
Phone: 304-342-1604

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

WISCONSIN – Medicaid
Website: http://dhswisconsin.gov/medicaid/publications/p-10095
Phone: 1-800-362-3002

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

WYOMING – Medicaid
Website: http://www.health.wyo.gov/healthcarefin/index.html
Telephone: 307-777-7531

To see if any more States have added a premium assistance program since November 3, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565