West Volusia Hospital Authority
BOARD OF COMMISSIONERS REGULAR MEETING
January 17, 2019 5:00 p.m.
DeLand City Hall
120 S. Florida Avenue, DeLand, FL

AGENDA

1. Call to Order Organizational Portion of Meeting

2. Organizational Meeting

3. Organization of New Board of Commissioners

    I. Swearing in of the Commissioners by Honorable Raul A. Zambrano

        A. Commissioner Dolores Guzman
        B. Commissioner Kathie Shepard
        C. Commissioner John Hill

    II. Election of Officers

        A. Open floor for nomination of Chair
            1. Close nominations
            2. Hold vote for Chair
        B. Chair continues with nominations and election of remaining officers
            1. Vice-Chair
            2. Secretary
            3. Treasurer

    III. Organizational Matters

        A. Motion and approval confirming location of Authority office and records remains the same

        B. Motion and approval of time and location for Authority meetings
            1. DeLand City Hall Commission Chambers, 120 S. Florida Avenue, DeLand, FL, 5:00 p.m.
            2. Dreggors, Rigsby & Teal, P.A., 1006 N. Woodland Blvd., DeLand FL, 5:00 p.m.
            3. DeLand Police Department Community Room, 219 W. Howry Avenue, DeLand, FL, 5:00 p.m.
            4. Advent Health DeLand (FHD) 701 West Plymouth Avenue, DeLand, FL, 5:00 p.m.
            5. Advent Health Fish Memorial (FHFM) 1745 Sterling Blvd., Deltona, FL, 5:00 p.m.
            6. Wayne Sanborn Center, 815 S. Alabama Ave., DeLand, FL 5:00 p.m.

        C. Citizens Advisory Committee Vacancies

    IV. Allow WVHA Commissioners short comments, concerns and requests for agenda items for regular meetings

4. Adjourn Organizational portion of meeting

W.V.H.A.
CITIZENS
ADVISORY
COMMITTEE
2018-2019

Judy Craig
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Ann Flowers
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Echolt54@gmail.com

John Hill

Updated 7-19-2018

West Volusia Hospital Authority
BOARD OF COMMISSIONERS REGULAR MEETING
January 17, 2019 commencing upon the conclusion of the Organizational Meeting
DeLand City Hall
120 S. FLORIDA AVENUE, DELAND, FL
AGENDA (continued)

5. Call to Order Regular meeting
6. Opening Observance followed by a moment of silence
7. Approval of Proposed Agenda
8. Consent Agenda:
    A. Approval of Minutes - Regular Meeting November 15, 2018
9. Citizens Comments
10. Reporting Agenda:
    A. UMR November/December Report – Written Submission
    B. FQHC Report - Laurie Asbury, CEO
       Northeast Florida Health Services, Inc. (NEFHS)
       d/b/a Family Health Source (FHS) November/December Report
11. Discussion Items:
    A. Commissioner Dolores Guzman CAC Appointees
        1. Gloria Osorio – CAC Application attached
        2. Julisa Rentas – CAC Application attached
    B. Community Life Center (CLC) Expanded Site Visit Write Up 2017-2018 (attached)
        1. Letter from CLC dated 12/4/2018 attached
    C. DRT Engagement Letter 2018-2019 Expanded Site Visits
        1. Rising Against All Odds
        2. Community Life Center
    D. POMCO/UMR Subrogation Settlement Offer $5,000.00
    E. UMR Administrative Services Agreement-TPA Matters
    F. POMCO duplicate funding December 2017 $578,359.20 (email dated 12/27/2018 attached)
    G. NEFHS Over Budget 2017-2018 $43,349.00
        1. Pharmacy $28,779.00
        2. Obstetrics $5,476.00
        3. Primary Care $9,094.00
    H. WVHA/UMR Health Benefit Summary Plan Description (attached)
    I. Downtown DeLand CRA: Notice of Amendment to Extend CRA Expiration from 9/30/2025 to 12/31/2036
    J. Follow Up Items
12. Finance Report
    A. November & December Financials
13. Legal Update
14. Commissioner Comments
15. Adjournment

WEST VOLUSIA HOSPITAL AUTHORITY
Board of Commissioners Regular Meeting
DeLand City Hall
120 S. Florida Avenue, DeLand, FL
November 15, 2018
5:00 p.m.

Those in Attendance:
Commissioner Kathie D. Shepard
Commissioner Barb Girtman
Commissioner Andy Ferrari
Commissioner Dolores Guzman
Commissioner Judy Craig

CAC Present:
Voloria Manning
Alissa Lapinsky
Michael Ray
Jacquie Lewis
Ann Flowers

Others Present:
Attorney for the Authority: Ted Small, Law Office of Theodore W. Small, P.A.
Accountant for the Authority: Ron Cantlay, Dreggors, Rigsby & Teal (DRT)
Administrative Support: Eileen Long, DRT

Call to Order

Chair Ferrari called the meeting to order. The meeting took place at DeLand City Hall, 120 S. Florida Avenue, DeLand, Florida, having been legally noticed in the Daytona Beach News-Journal, a newspaper of general circulation in Volusia County. Chair Ferrari opened the meeting with a moment of silence followed by the Pledge of Allegiance.

Approval of Proposed Agenda

Motion 091 – 2018 Commissioner Guzman motioned to approve the agenda as presented. Commissioner Craig seconded the motion. The motion passed unanimously.

Consent Agenda
Approval of Minutes Regular Meeting October 18, 2018

Motion 092 – 2018 Commissioner Shepard motioned to approve the consent agenda. Commissioner Craig seconded the motion. The motion passed unanimously.

Citizens Comments

There were two.

Reporting Agenda

UMR October Report – Written Submission
FQHC Report, Laurie Asbury, CEO, Northeast Florida Health Services, Inc. d/b/a Family Health Source (FHS) October Report

Hospital Quarterly Report

Florida Hospital Fish Memorial - Rob Deininger, President and/or Eric Ostarly, CFO
Florida Hospital DeLand – Lorenzo Brown, CEO and/or Kyle Glass, CFO

Mr. Eric Ostarly and Mr. Kyle Glass addressed the Board and presented a Power Point Presentation update with an update on the Florida Hospital Community Care Program (attached) along with several additional updates regarding both hospitals.

Discussion Items

UMR Administrative Services Agreement (under current legal review)

Mr. Ted Small updated the Board as to the progress he was making with some provisions in the UMR Administrative Services Agreement (ASA) and his continued negotiations. He was not currently able to recommend that the Board sign off on this agreement at this time, but he believed that there was still room for negotiations and further discussion. Mr. Small suggested that the Board might want to tentatively schedule a meeting in December should he and UMR finalize negotiations of the ASA.

There was Board discussion and agreement that the date to consider would be Thursday, December 20, 2018, which is the third Thursday of the month.

Ms. Long explained that she would need to submit the meeting notice to the Daytona Beach News-Journal by Thursday, December 6, 2018 in order for the ad to publish on Thursday, December 13, 2018.

Mr. Small suggested, that if this meeting is to come to fruition, it should be noticed as a general meeting in case other matters arise between then and now.

Motion 093 – 2018 Commissioner Guzman motioned to tentatively schedule a general meeting for Thursday, December 20, 2018 should one become necessary. Commissioner Craig seconded the motion.

Citizen Tanner Andrews suggested that the meeting be held in the offices of Dreggors, Rigsby and Teal.

Mr. Small suggested that the meeting should be published to be held at any of the WVHA Board of Commissioner approved meeting locations, depending upon availability.

Motion 093 – 2018 (AMENDED) Commissioner Guzman amended her motion to tentatively schedule a general meeting for Thursday, December 20, 2018 should one become necessary at any one of the WVHA Board approved meeting locations, depending upon availability. Commissioner Craig seconded the amended motion. The motion passed unanimously.

Site Visit Write Ups 2017-2018

Florida Department of Health – Dental Services
Rising Against All Odds (RAAO) – Outreach/HIV/Aids Counseling
Stewart-Marchman-Act (SMA) ARNP @ THND
SMA-Homeless Program
The House Next Door (THND)-Therapeutic Services
The Neighborhood Center (TNC)-Outreach Services
Community Legal Services of Mid-Florida
Hispanic Health Initiative

Mr. Ron Cantlay addressed the Board seeking guidance on how to proceed with DRT's recommendation to perform an expanded site visit review for RAAO for fiscal year ending 9/30/2018 due to the numerous findings when performing the initial site visit review.

Ms. Brenda Flowers addressed the Board and explained that she had delegated the invoicing of the WVHA clients to another staff member and that she has since reclaimed that duty. Also, their system database "crashed" and they are now in the process of installing a Microsoft Office database and setting up electronic records. She believes this will eliminate the billing confusion once it is fully implemented.

The Board asked Ms. Flowers when she believed RAAO would be ready for DRT to return to perform an additional site visit compliance review? They asked her if she felt that March of 2019 would be far out enough for them to address these matters?

Ms. Flowers had her IT representative with her and he asked if it could be pushed back to May of 2019?

There was Board consent to schedule the expanded site visit review for May of 2019.

There was further discussion in regards to what types of photo ID's were acceptable and that admission to an institution located within the WVHA Taxing District does not constitute fulfillment of the residency requirements.

Ms. Dixie Morgese, Executive Director, Healthy Start Coalition of Flagler and Volusia (HSCFV) addressed the Board and suggested that her organization, Stewart-Marchman-Act (SMA), RAAO, The Neighborhood Center and possibly Community Legal Services of Mid-Florida could convene to try and come up with a solution to the difficulties with

their collective patient populations and verification of West Volusia residency with this transient and homeless population.

There was Board consent that this could be achieved through a group email between HSCFV, SMA, The Neighborhood Center, RAAO, Community Legal Services of Mid-Florida and Commissioner Shepard would like to be included in this group email, stating that her email is kathieshepard@gmail.com.

Check Signing Schedule Bi-Monthly Accounts Payable 2019

Motion 094 – 2018 Commissioner Shepard motioned to approve the 2019 check signing schedule. Commissioner Guzman seconded the motion. The motion passed unanimously.

Emergency Medicine Professionals, P.A. (EMPros) letter dated 10/15/2018 to Attorney Theodore W. Small (attached)

Mr. Small explained that the 20 year agreement between the hospital and the Authority is a completely separate set of agreements than this 13th Addendum to Physician Services, which is an add on agreement to the one entered into with the hospitals in 2000 and ends in 2020. This agreement, Primary Care Physicians Indigent Hospital Patient Program Reimbursement was first agreed to in October of 2005. This was only done because, at the time, primary care physicians were actually going to the hospitals to attend to their patients and they wanted to be paid. This had not been a part of the 20 year agreement with the hospital and the Authority. This agreement has been renewed year after year with no involvement of EMPros, but rather was between the WVHA and the hospitals. The hospital directly contracts with EMPros. How does the Board want to respond to this request?

Ms. Maureen France, Physician Liaison, EMPros addressed the Board and admitted that times have changed and funding is tight, there is limited federal funding available and now they wish to negotiate directly with the WVHA.

Mr. Small suggested that the Board take this as a first pass/informational meeting and not try to resolve it tonight. Rather, the Board give him the authority to negotiate with EMPros to bring something back before the Board for consideration.

There was Board consent that Mr. Small pursue negotiations with EMPros and bring something back before the Board for consideration.

Good Samaritan Clinic 2018-2019 WVHA Funding

Ms. Mary Gusky, Administrator, Good Samaritan Clinic (GSC) read a prepared written letter to the WVHA Board (attached) whereby GSC Board determined that at this time they felt that GSC is in a good position to move forward on their own without the grant money requested from the WVHA for fiscal year 2018-2019. Ms. Gusky closed with a sincere thank you to the Board for 11 years of financial support.

Follow Up Items

There were none.

Financial Report

Mr. Ron Cantlay, DRT reviewed for the Board the October financial statements (see attached).

Motion 095 – 2018 Commissioner Guzman motioned to pay bills totaling $2,742,457.61 (see attached). Commissioner Shepard seconded the motion. The motion passed unanimously.

Legal Update

There was not a written legal update submission. Mr. Small asked each Board member to reach out to him to let him know how they wanted to proceed with the hospitals 20 year contract that will be expiring in 2020.

Commissioner Comments

There being no further business to come before the Board, the meeting was adjourned.

Adjournment

Andy Ferrari, Chair

UMR

December 20, 2018

Submission Report for WVHA Board Members

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Enrollment Processing

Applications Processed by Fiscal Year for the Period of 10/1/2018 to Present

Applications Processed 10/01/2018 - Present

FiscalYr	Month Received	APPROVED	DENIED	PENDING	Grand Total	Approval Percentage
FY1819	201810	318	16	22	356	89.33%
	201811	207	13	55	275	75.27%
	201812					
	201901					
	201902					
	201903					
	201904					
	201905					
	201906					
	201907					
	201908					
	201909					
Grand Total		525	29	77	631	83.20%

Applications Processed by Fiscal Year – Approval Percentage

Fiscal Year	Applications Processed	Average Approval Percentage
FY1516	2670	82.28%
FY1617	3963	86.60%
FY1718	4247	90.65%
FY1819	631	83.20%

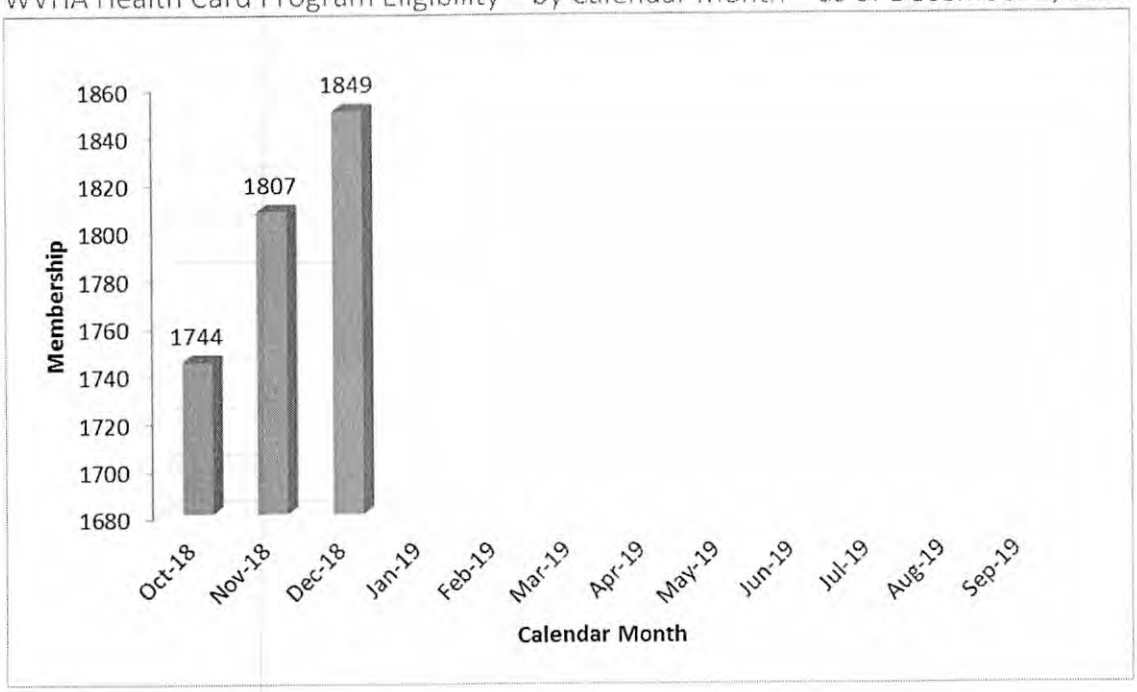
Based on Fiscal year

Enrollment Applications – Denial Summary Report

Period	Approved Apps	Pctg	Denied Apps	Pctg	Pending Apps	Pctg	Total Apps
FY1819	525	83.20%	29	4.60%	77	12.20%	631
201810	318	89.33%	16	4.49%	22	6.18%	356
Active Eligible	318	100.00%		0.00%		0.00%	318
Declined - Member Exceeds Asset Level		0.00%		0.00%		0.00%	0
Declined - ACA PREM COST <8% INCOME		0.00%		0.00%		0.00%	0
Declined - Member Exceeds Income Level		0.00%	11	0.00%		0.00%	11
Declined - MEMBER HAS MEDICAID COVERAGE		0.00%		0.00%		0.00%	0
Declined - MEMBER HAS OTHER COVERAGE		0.00%	1	0.00%		0.00%	1
Declined - Req'd Documentation Missing		0.00%	4	0.00%		0.00%	4
Declined - Multiple Reasons		0.00%		0.00%		0.00%	0
Pending - Multiple Reasons		0.00%		0.00%	22	0.00%	22
Pending - Unknown		0.00%		0.00%		0.00%	0
TRM - MEMBER HAS MEDICAID COVERAGE		0.00%		0.00%		0.00%	0
201811	207	75.27%	13	4.73%	55	20.00%	275
Active Eligible	207	100.00%		0.00%		0.00%	207
Declined - Member Exceeds Asset Level		0.00%		0.00%		0.00%	0
Declined - ACA PREM COST <8% INCOME		0.00%		0.00%		0.00%	0
Declined - Member Exceeds Income Level		0.00%	9	0.00%		0.00%	9
Declined - MEMBER HAS MEDICAID COVERAGE		0.00%		0.00%		0.00%	0
Declined - MEMBER HAS OTHER COVERAGE		0.00%	1	0.00%		0.00%	1
Declined - Req'd Documentation Missing		0.00%	2	0.00%		0.00%	2
Declined - Multiple Reasons		0.00%	1	0.00%		0.00%	1
Pending - Multiple Reasons		0.00%		0.00%	55	0.00%	55
Pending - Unknown		0.00%		0.00%		0.00%	0
TRM - MEMBER HAS MEDICAID COVERAGE		0.00%		0.00%		0.00%	0

Note that because patients can and do become eligible and/or terminate every day of the month, when reporting by month, the most current status only will be reflected on the monthly reports. If a member is approved but then is denied/termed in the same or subsequent month, the status of denied/termed will be reported and the approved status will be removed.

WVHA Health Card Program Eligibility – by Calendar Month – as of December 1, 2018

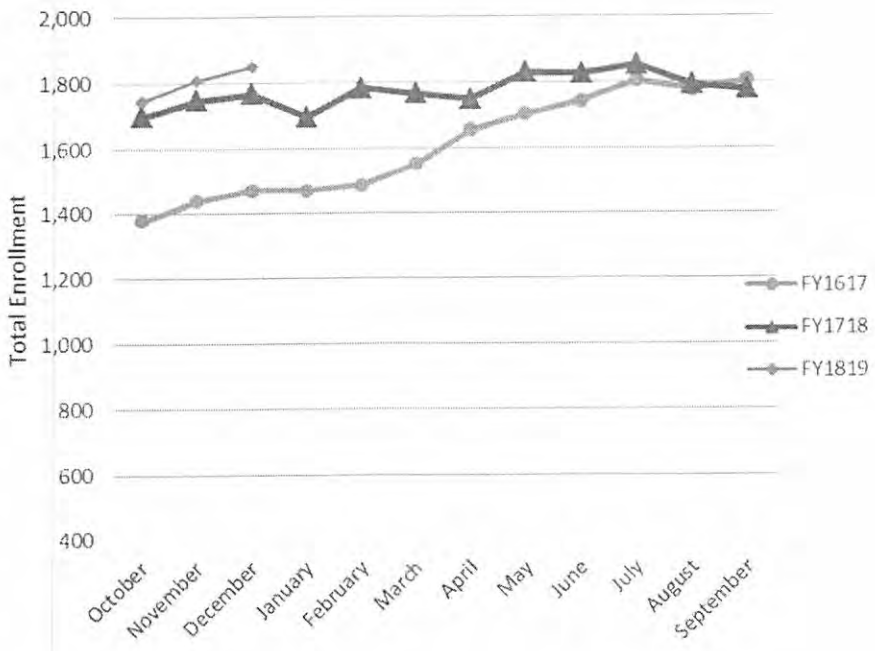


Eligibility reported above reflects eligibility as of the first of each month.

As of December 1, 2018, total program eligibility was 1,849 patients.

WVHA Enrollment by Fiscal Year – as of December 1, 2018

WVHA Enrollment By Fiscal Year	
Month of Fiscal Year	FY1819
October	1,744
November	1,807
December	1,849
January	
February	
March	
April	
May	
June	
July	
August	
September	
Grand Total	5,400



Medical and Prescription Drug Claim Data

Pharmacy Claims by Fiscal Year by Service Month (Month Prescription Filled)

	FY1819				
Month	Drug Costs	Dispensing Fee Less Copayments	Total Costs	Total Rx's Filled	Avg Cost Per Rx
October	$55,005.45	$7,661.22	$62,666.67	3,451	$18.16
November			$0.00		#DIV/0!
December			$0.00		#DIV/0!
January			$0.00		#DIV/0!
February			$0.00		#DIV/0!
March			$0.00		#DIV/0!
April			$0.00		#DIV/0!
May			$0.00		#DIV/0!
June			$0.00		#DIV/0!
July			$0.00		#DIV/0!
August			$0.00		#DIV/0!
September			$0.00		#DIV/0!
Grand Total	$55,005.45	$7,661.22	$62,666.67	3,451	$18.16

Combined Medical Costs (as of Claims Payment through 11/30/2018)

Fiscal Year	Hospital	Lab	PCP	Specialty	Facility Physicians	Pharmacy	Total Costs	Member Months	Overall Per Member Per Month (PMPM)	Hospital PMPM	Lab PMPM	PCP PMPM	Specialty PMPM	Pharmacy PMPM
FY1819	**$78,902.34**	**$90,113.79**	**$199,151.16**	**$538,011.76**	**$0.00**	**$62,666.67**	**$968,845.72**	**3,656**	**$265.00**	**$21.58**	**$24.65**	**$54.47**	**$147.16**	**$17.14**
October	$14,319.08	$64,081.46	$124,186.81	$351,047.84	$0.00	$62,666.67	$616,301.86	1,807	$341.06	$7.92	$35.46	$68.73	$194.27	$34.68
November	$64,583.26	$26,032.33	$74,964.35	$186,963.92	$0.00		$352,543.86	1,849	$190.67	$34.93	$14.08	$40.54	$101.12	$0.00
December							$0.00							
January							$0.00							
February							$0.00							
March							$0.00							
April							$0.00							
May							$0.00							
June							$0.00							
July							$0.00							
August							$0.00							
September							$0.00							
Grand Total	**$78,902.34**	**$90,113.79**	**$199,151.16**	**$538,011.76**	**$0.00**	**$62,666.67**	**$968,845.72**	**3,656**	**$265.00**	**$21.58**	**$24.65**	**$54.47**	**$147.16**	**$17.14**

Medical and pharmacy costs are reported on a paid basis

PCP Encounter Claims by Clinic by Month (as of Claims Payment through 11/30/2018)

	FY1819					
Month	NEFHS Deland	NEFHS Deltona	NEFHS Pierson	NEFHS Stone Street	NEFHS Daytona	Total
October	453	511	158	0	19	1,141
November	274	358	85	0	4	721
December						0
January						0
February						0
March						0
April						0
May						0
June						0
July						0
August						0
September						0
Grand Total	727	869	243	0	23	1,862

PCP encounter claims are reported on a paid basis

Specialty Care Services by Specialty – Top 25 (November, 2018)

SPECIALTY CARE SERVICES BY SPECIALTY - TOP 25 FOR NOVEMBER							
Order	**SPECIALITY**	**Unique Patients**	**Claim Volume**		**Paid**		**Cost Per Patient**
1	Gastroenterology	69	104	$	14,736.06	$	141.69
2	Physical & Occupational Therapy	36	112	$	13,594.20	$	121.38
3	Orthopedic Surgery	56	73	$	13,506.31	$	185.02
4	Cardiovascular Diseases	48	84	$	13,064.02	$	155.52
5	Radiology	222	374	$	12,460.50	$	33.32
6	CLINIC	32	108	$	11,055.35	$	102.36
7	Internal Medicine	43	65	$	11,052.03	$	170.03
8	Pain Management	40	46	$	10,688.56	$	232.36
9	Anesthesiology	75	95	$	9,847.42	$	103.66
10	Surgery Center	18	20	$	8,515.95	$	425.80
11	Neurology	34	47	$	6,171.80	$	131.31
12	Infectious Diseases	28	48	$	5,837.38	$	121.61
13	Pulmonary Medicine	38	56	$	5,767.63	$	102.99
14	Hematology Oncology	39	65	$	5,758.71	$	88.60
15	Ophthalmology	38	47	$	5,646.53	$	120.14
16	Urology	25	31	$	5,402.53	$	174.28
17	Nurse Anesthetist	36	40	$	3,748.34	$	93.71
18	Nurse Practitioner	33	34	$	2,969.84	$	87.35
19	Optometry	28	28	$	2,940.97	$	105.03
20	Obstetrics & Gynecology	17	26	$	2,833.87	$	109.00
21	Dermatology	25	32	$	2,785.20	$	87.04
22	General Surgery	4	5	$	2,105.90	$	421.18
23	Cardiology	16	21	$	1,985.40	$	94.54
24	Social Worker	24	29	$	1,974.19	$	68.08
25	Rheumatology	18	18	$	1,789.21	$	99.40

New Items

Subrogation Lien Reduction Request

POMCO/UMR has been working on a subrogation case regarding a WVHA health card member claims that have confirmed third party liability.

In our attempt to recover the funds for WVHA, the heath card member's attorney is requesting that WVHA reduce the liability from $8,776.44 down to $5,000.

As a reminder, on subrogation cases we normally see a request for a 1/3 reduction on the lien whenever a member has employed an attorney with the goal of keeping as much of the third party settlement in the hands of the member/plaintiff. The decision however is always up to the program sponsor.

Out statement to the attorney is attached.

POMCO
EXPERIENCE. EXCELLENCE.

2425 James Street
Syracuse, NY 13206
Telephone: 315.937.2873
Facsimile: 844.690.9209

October 25, 2018

Payas Payas Payas, LLP
1676-B Providence Blvd.
Deltona, FL 32725

VIA FACSIMILE
407-581-8989

Re: West Volusia Hospital Authority Health Plan
Member: [redacted]
Member ID: 891215851
D/A: 5/27/17

To Wom It May Concern:

Enclosed is the updated claims listing relating to the above accident.

Please be advised the West Volusia Hospital Authority Health Plan is self-funded and contains an exclusion for payments received as the result of a "Third Party Claim or Settlement." By definition, a "Third Party Claim" is when you receive payment or are reimbursed as the result of legal action or settlement for services or supplies obtained in connection with an accidental injury. Therefore, the plan must be reimbursed for the expenses it incurs relating to Mr. Riley's accident of May 27, 2017. The plan has paid $8,776.44 to date.

If you need additional information, please contact me.

Sincerely,

Kimberley E. Bigos

Kimberley E. Bigos

/kb

Enclosure

UMR

January 17, 2019

Submission Report for WVHA Board Members

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Enrollment Processing

Applications Processed by Fiscal Year for the Period of 10/1/2018 to Present

Applications Processed 10/01/2018 - Present

FiscalYr	Month Received	APPROVED	DENIED	PENDING	Grand Total	Approval Percentage
FY1819	201810	320	16	18	354	90.40%
	201811	256	16	55	327	78.29%
	201812	174	6	61	241	72.20%
	201901					
	201902					
	201903					
	201904					
	201905					
	201906					
	201907					
	201908					
	201909					
Grand Total		750	38	134	922	81.34%

Applications Processed by Fiscal Year – Approval Percentage

Fiscal Year	Applications Processed	Average Approval Percentage
FY1516	2670	82.28%
FY1617	3963	86.60%
FY1718	4247	90.65%
FY1819	750	81.34%

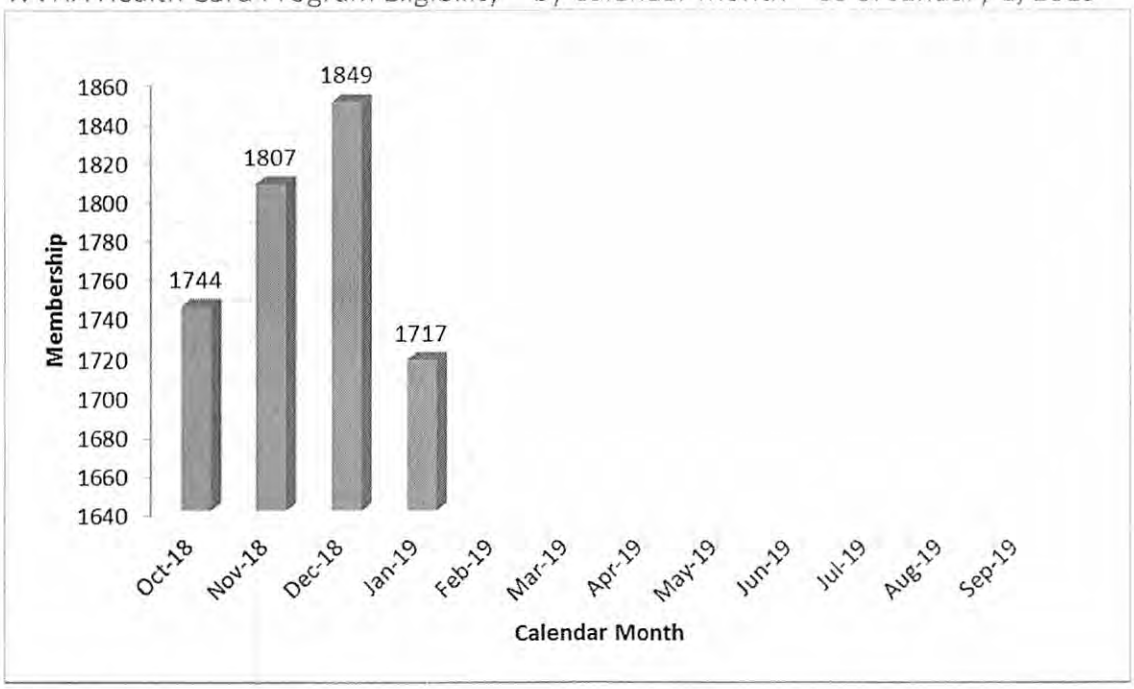
Based on Fiscal year

Enrollment Applications – Denial Summary Report

Period	Approved Apps	Pctg	Denied Apps	Pctg	Pending Apps	Pctg	Total Apps
FY1819	750	81.34%	38	4.12%	134	14.53%	922
201810	320	90.40%	16	4.52%	18	5.08%	354
Active Eligible	320	100.00%		0.00%		0.00%	320
Declined - Member Exceeds Asset Level		0.00%		0.00%		0.00%	0
Declined - ACA PREM COST <8% INCOME		0.00%		0.00%		0.00%	0
Declined - Member Exceeds Income Level		0.00%	11	0.00%		0.00%	11
Declined - MEMBER HAS MEDICAID COVERAGE		0.00%		0.00%		0.00%	0
Declined - MEMBER HAS OTHER COVERAGE		0.00%	1	0.00%		0.00%	1
Declined - Req'd Documentation Missing		0.00%	4	0.00%		0.00%	4
Declined - Multiple Reasons		0.00%		0.00%		0.00%	0
Pending - Multiple Reasons		0.00%		0.00%	18	0.00%	18
Pending - Unknown		0.00%		0.00%		0.00%	0
TRM - MEMBER HAS MEDICAID COVERAGE		0.00%		0.00%		0.00%	0
201811	256	78.29%	16	4.89%	55	16.82%	327
Active Eligible	256	100.00%		0.00%		0.00%	256
Declined - Member Exceeds Asset Level		0.00%		0.00%		0.00%	0
Declined - ACA PREM COST <8% INCOME		0.00%		0.00%		0.00%	0
Declined - Member Exceeds Income Level		0.00%	9	0.00%		0.00%	9
Declined - MEMBER HAS MEDICAID COVERAGE		0.00%	1	0.00%		0.00%	1
Declined - MEMBER HAS OTHER COVERAGE		0.00%	1	0.00%		0.00%	1
Declined - Req'd Documentation Missing		0.00%	4	0.00%		0.00%	4
Declined - Multiple Reasons		0.00%	1	0.00%		0.00%	1
Pending - Multiple Reasons		0.00%		0.00%	55	0.00%	55
Pending - Unknown		0.00%		0.00%		0.00%	0
TRM - MEMBER HAS MEDICAID COVERAGE		0.00%		0.00%		0.00%	0
201812	174	72.20%	6	2.49%	61	25.31%	241
Active Eligible	174	100.00%		0.00%		0.00%	174
Declined - Member Exceeds Asset Level		0.00%	6	0.00%		0.00%	6
Declined - ACA PREM COST <8% INCOME		0.00%		0.00%		0.00%	0
Declined - Member Exceeds Income Level		0.00%		0.00%		0.00%	0
Declined - MEMBER HAS MEDICAID COVERAGE		0.00%		0.00%		0.00%	0
Declined - MEMBER HAS OTHER COVERAGE		0.00%		0.00%		0.00%	0
Declined - Req'd Documentation Missing		0.00%		0.00%		0.00%	0
Declined - Multiple Reasons		0.00%		0.00%		0.00%	0
Pending - Multiple Reasons		0.00%		0.00%	61	0.00%	61
Pending - Unknown		0.00%		0.00%		0.00%	0
TRM - MEMBER HAS MEDICAID COVERAGE		0.00%		0.00%		0.00%	0

Note that because patients can and do become eligible and/or terminate every day of the month, when reporting by month, the most current status only will be reflected on the monthly reports. If a member is approved but then is denied/termed in the same or subsequent month, the status of denied/termed will be reported and the approved status will be removed.

WVHA Health Card Program Eligibility – by Calendar Month – as of January 1, 2019

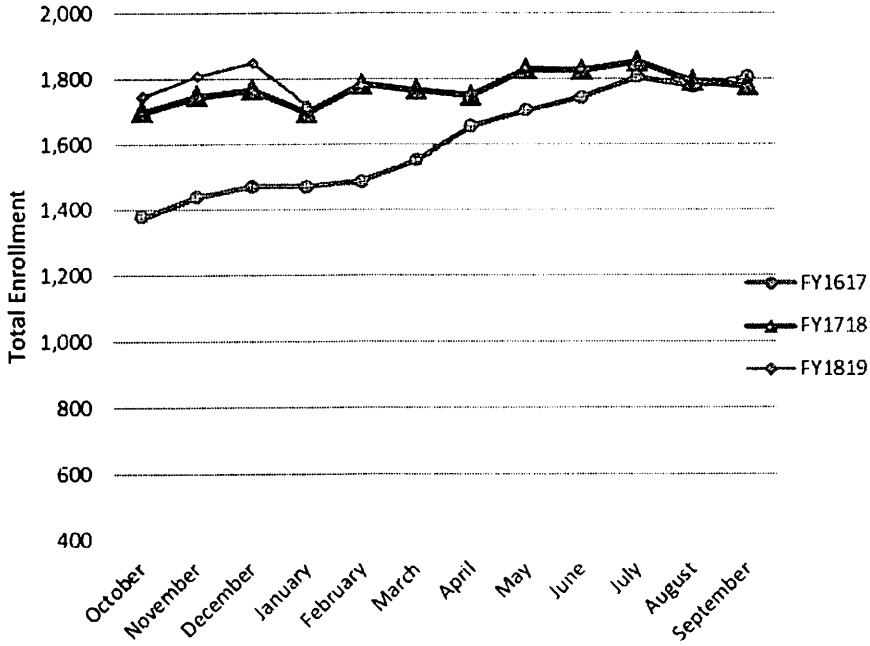


Eligibility reported above reflects eligibility as of the first of each month.

As of January 1, 2019, total program eligibility was 1,717 patients.

WVHA Enrollment by Fiscal Year – as of January 1, 2019

WVHA Enrollment By Fiscal Year	
Month of Fiscal Year	FY1819
October	1,744
November	1,807
December	1,849
January	1,717
February	
March	
April	
May	
June	
July	
August	
September	
Grand Total	7,117



Medical and Prescription Drug Claim Data

Pharmacy Claims by Fiscal Year by Service Month (Month Prescription Filled)

	FY1819				
Month	Drug Costs	Dispensing Fee Less Copayments	Total Costs	Total Rx's Filled	Avg Cost Per Rx
October	$55,005.45	$7,661.22	$62,666.67	3,451	$18.16
November	$55,658.13	$7,008.54	$62,666.67	3,157	$19.85
December					
January					
February					
March					
April					
May					
June					
July					
August					
September					
Grand Total	$110,663.58	$14,669.76	$125,333.34	6,608	$18.97

Combined Medical Costs (as of Claims Payment through 12/31/2018)

Fiscal Year	Hospital	Lab	PCP	Specialty	Facility Physicians	Pharmacy	Total Costs	Member Months	Overall Per Member Per Month (PMPM)	Hospital PMPM	Lab PMPM	PCP PMPM	Specialty PMPM	Pharmacy PMPM
FY1819	**$339,937.98**	**$155,167.55**	**$290,560.43**	**$843,274.48**	**$0.00**	**$125,333.34**	**$1,754,273.78**	**5,373**	**$326.50**	**$63.27**	**$28.88**	**$54.08**	**$156.95**	**$23.33**
October	$14,319.08	$64,081.46	$124,186.81	$351,047.84	$0.00	$62,666.67	$616,301.86	1,807	$341.06	$7.92	$35.46	$68.73	$194.27	$34.68
November	$64,583.26	$26,032.33	$74,964.35	$186,963.92	$0.00	$62,666.67	$415,210.53	1,849	$224.56	$34.93	$14.08	$40.54	$101.12	$33.89
December	$261,035.64	$65,053.76	$91,409.27	$305,262.72	$0.00		$722,761.39	1,717	$420.94	$152.03	$37.89	$53.24	$177.79	$0.00
January							$0.00							
February							$0.00							
March							$0.00							
April							$0.00							
May							$0.00							
June							$0.00							
July							$0.00							
August							$0.00							
September							$0.00							
Grand Total	**$339,937.98**	**$155,167.55**	**$290,560.43**	**$843,274.48**	**$0.00**	**$125,333.34**	**$1,754,273.78**	**5,373**	**$326.50**	**$63.27**	**$28.88**	**$54.08**	**$156.95**	**$23.33**

Medical and pharmacy costs are reported on a paid basis

PCP Encounter Claims by Clinic by Month (as of Claims Payment through 12/31/2018)

	FY1819					
Month	NEFHS Deland	NEFHS Deltona	NEFHS Pierson	NEFHS Stone Street	NEFHS Daytona	Total
October	453	511	158	0	19	1,141
November	274	358	85	0	4	721
December	338	296	121	0	13	768
January						0
February						0
March						0
April						0
May						0
June						0
July						0
August						0
September						0
Grand Total	1,065	1,165	364	0	36	2,630

PCP encounter claims are reported on a paid basis

Specialty Care Services by Specialty – Top 25 (December, 2018)

SPECIALTY CARE SERVICES BY SPECIALTY - TOP 25 FOR DECEMBER							
Order	**SPECIALTY**	**Unique Patients**	**Claim Volume**		**Paid**		**Cost Per Patient**
1	Cardiovascular Diseases	62	123	$	48,279.63	$	392.52
2	Radiology	412	786	$	30,653.77	$	39.00
3	Hematology Oncology	58	129	$	27,731.83	$	214.98
4	Internal Medicine	59	95	$	18,140.65	$	190.95
5	Physical & Occupational Therapy	38	128	$	16,152.40	$	126.19
6	Orthopedic Surgery	70	87	$	16,002.46	$	183.94
7	CLINIC	34	127	$	15,484.33	$	121.92
8	Gastroenterology	64	97	$	14,240.92	$	146.81
9	Pain Management	49	80	$	14,087.12	$	176.09
10	Surgery Center	28	30	$	12,618.30	$	420.61
11	Ophthalmology	62	70	$	11,181.02	$	159.73
12	Anesthesiology	54	58	$	9,572.66	$	165.05
13	Urology	36	53	$	8,863.27	$	167.23
14	Pulmonary Medicine	31	54	$	7,723.35	$	143.03
15	General Surgery	8	14	$	6,610.48	$	472.18
16	Neurology	44	57	$	5,909.91	$	103.68
17	Podiatry	28	49	$	4,483.56	$	91.50
18	Infectious Diseases	26	48	$	4,225.29	$	88.03
19	Obstetrics & Gynecology	16	23	$	3,760.18	$	163.49
20	Nurse Anesthetist	54	67	$	3,611.58	$	53.90
21	Nurse Practitioner	32	38	$	3,181.79	$	83.73
22	Optometry	30	35	$	3,109.71	$	88.85
23	Family Practice	27	28	$	2,669.28	$	95.33
24	Dermatology	18	21	$	2,066.60	$	98.41
25	Chiropractor	12	19	$	1,840.29	$	96.86

New Items

December 2017 Duplicate Claims Funding Request Error

The UMR Treasury department has been working on closing out all of the old POMCO bank accounts used for customer claim funding. During that process, they learned that there was quite a large sum of funds still remaining in the account for the WVHA health card program in the amount of $578,359.20.

Upon that discovery we began to research how this occurred given the unexpected large sum of funds. We found that the excess funds remaining in the old POMCO Chase account are based on a duplicate funding request that occurred in December of 2017. During that time of year we sent a special fund request (December 15th) for the Hospital facility claims that were previously denied prior to the end of WVHA's 2016/17 fiscal year due to them exhausting the budget. That funding request was in the amount of *$595,913.23*. We believe that same amount was included again in error during the next WVHA regularly scheduled check funding request on December 22, 2017.

At that time we had very large gaps in staffing of the POMCO legacy teams after the acquisition by UMR and we believe this was missed while our oversight was limited.

That being said, with the 7/1/2018 migration to UMR we have full reconciliation details of the current UMR owned funding account used for the WVHA health card program and we can share all reconciliation details on a monthly basis going forward to help prevent this from happening again in the future. The UMR funding area can provide the reconciliation reports between the 10 and the 15th of the month following each reconciliation month and will provide to DRT accordingly.

Lastly, we have found that the old POMCO Chase account did have one un-cashed provider check in the amount of $133.16 from a February 16, 2018 date of service that will be returned as well.

We sincerely apologize for the inconveniences that this brings and we are confident that the UMR protocols in place would prevent this from happening in the future while on the UMR platforms.

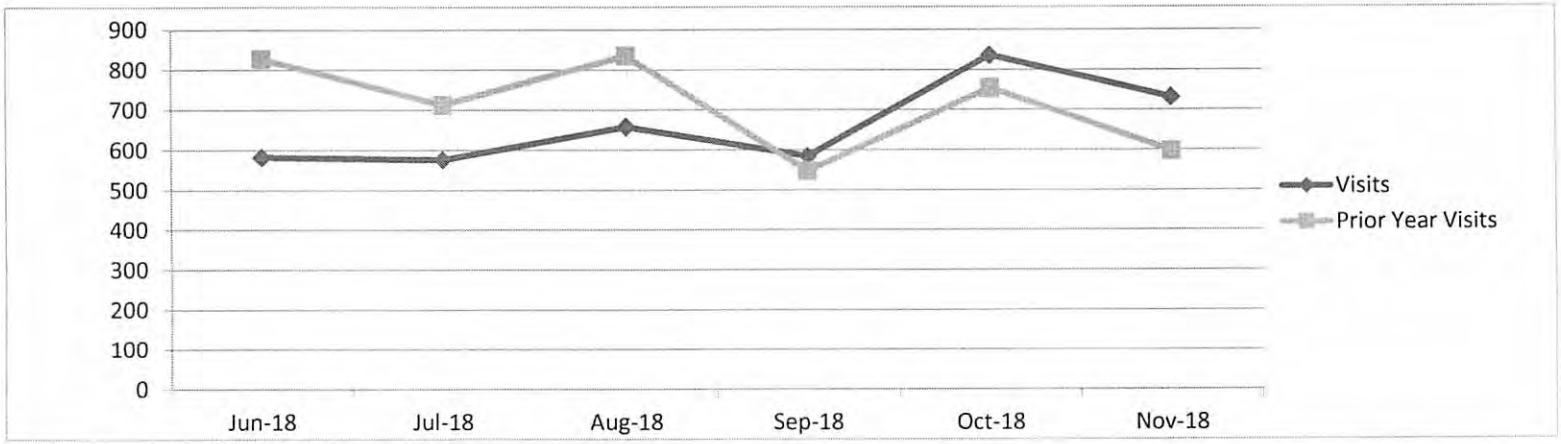
The total sum being returned to DRT on behalf of the WVHA health card program is **$595,913.23**. That accounts for the December 22, 2017 duplicate funding request of $596,046.39 as well as an un-cashed provider check payment of $133.16 from a February 16, 2018 date of service.

FAMILY Health Source

Northeast Florida Health Services
November-18

Patient Visits

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Visits	582	576	658	585	836	731
Prior Year Visits	828	713	835	548	754	598

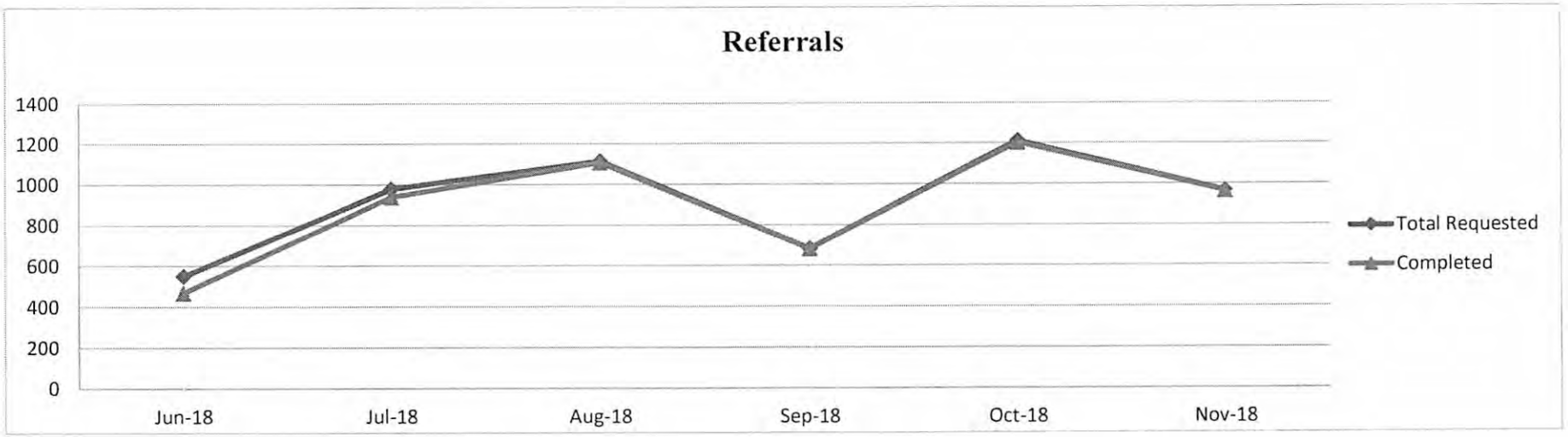


Patient Visits by Location

Location	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Deland Medical	212	234	282	244	348	309
Deltona Medical	336	249	299	248	389	322
Pierson Medical	21	76	69	84	92	90
Daytona	13	17	8	9	7	10
Total	582	576	658	585	836	731

Referrals

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
NEFHS Providers (refer to footnote 1)	154	266	295	183	380	310
Internal Specialty Providers (refer to footnote 2	396	712	820	500	832	656
Total	550	978	1115	683	1212	966
Outstanding NEFHS Providers	11	3	0	0	0	0
Outstanding Int. Speciality Providers	70	36	8	1	9	1
Completed	469	939	1107	682	1203	965
Total Requested	550	978	1115	683	1212	966



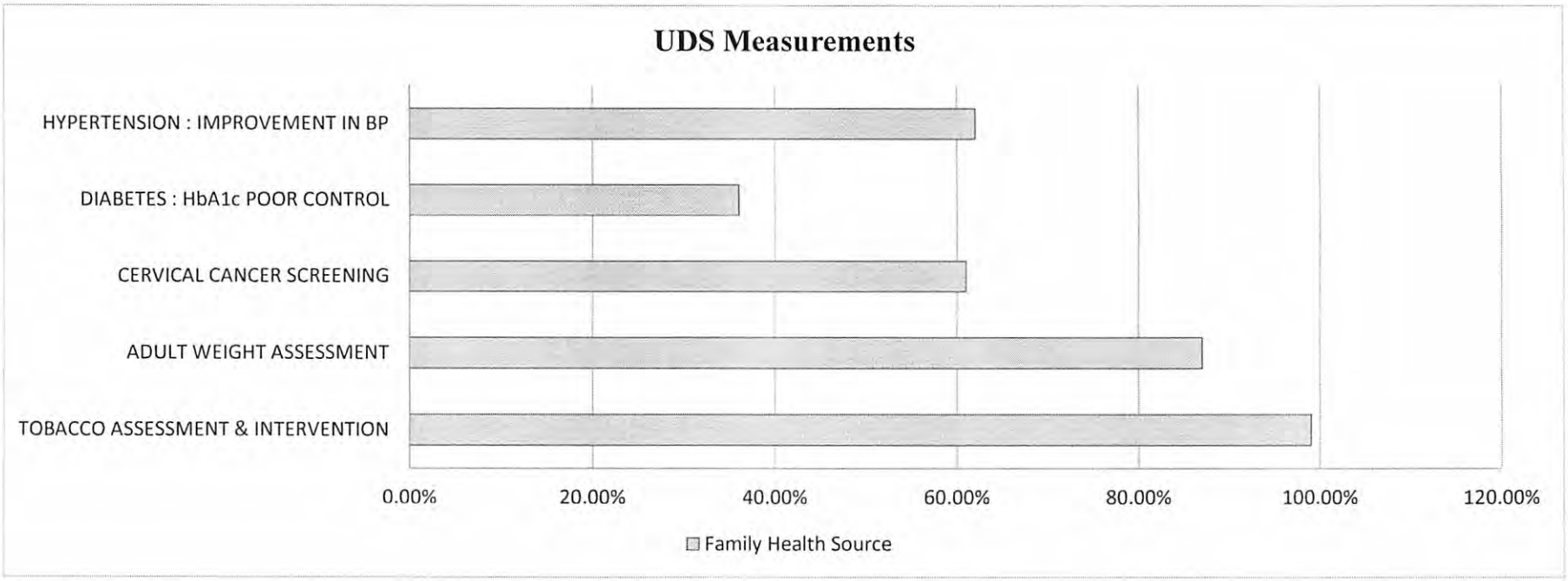
1 NEFHS provider referrals are generated by NEFHS PCP for imaging and durable medical equipment (DME).
2 Internal specialty provider referrals are generated by NEFHS PCP for consultation with a specialist.

Appointment Times

Location	Provider	Appointments
Daytona	Johnson	Same Day
DeLand	Kodish	Same Day
DeLand	Smith	Same Day
Deland	Hoblick	Same Day
DeLand	Sanchez	Same Day
DeLand	Vasanji	Same Day
Deltona	Baldassarre	Same Day
Deltona	Rodriguez	Same Day
Deltona	Macalua	Same Day
Deltona	Mancini	Same Day
Pierson	Roberson	Same Day
Pierson	Kessack	Same Day

UDS Measures

Clinical Measures for the month of October 2017	Family Health
TOBACCO ASSESSMENT & INTERVENTION	99.00%
ADULT WEIGHT ASSESSMENT	87.00%
CERVICAL CANCER SCREENING	61.00%
DIABETES : HbA1c POOR CONTROL	36.00%
HYPERTENSION : IMPROVEMENT IN BP	62.00%

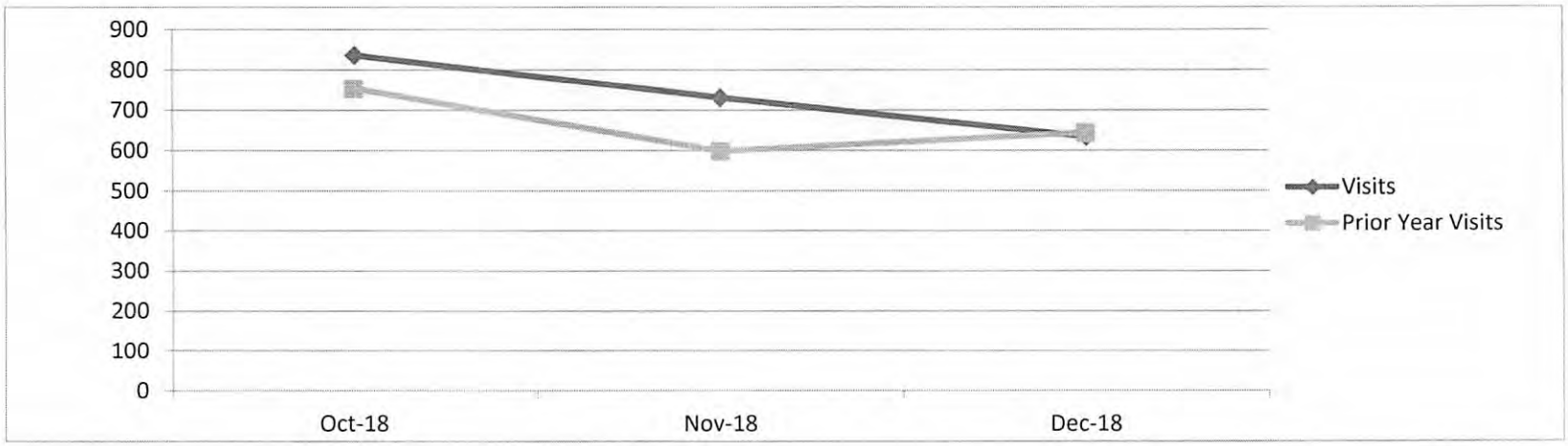


FAMILY Health Source

Northeast Florida Health Services
December-18

Patient Visits

	Oct-18	Nov-18	Dec-18
Visits	836	731	634
Prior Year Visits	754	598	644

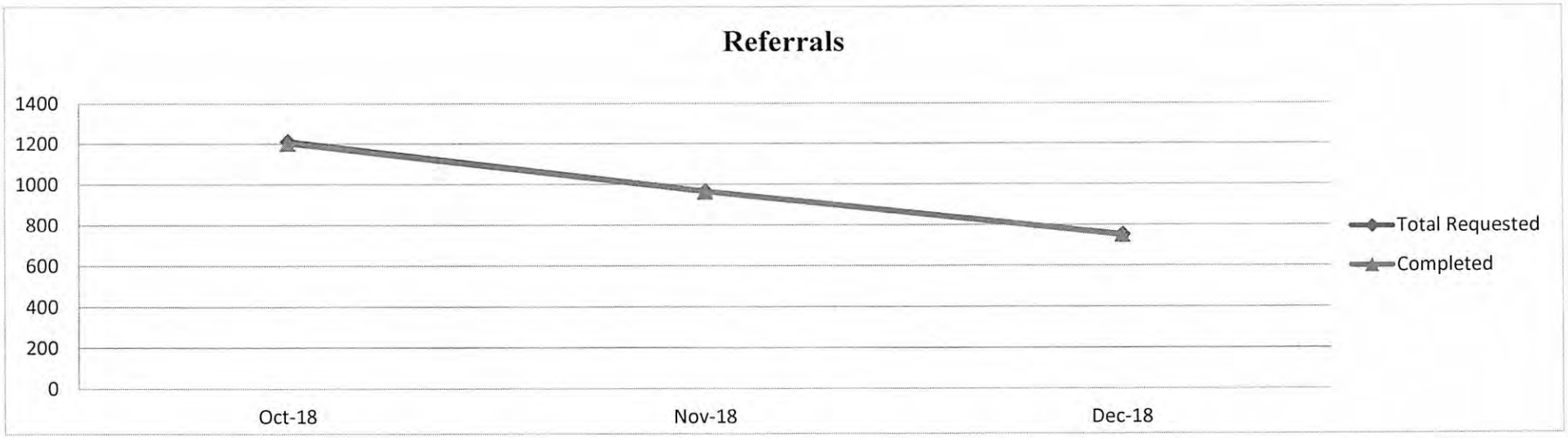


Patient Visits by Location

Location	Oct-18	Nov-18	Dec-18
Deland Medical	348	309	258
Deltona Medical	389	322	223
Pierson Medical	92	90	80
Daytona	7	10	73
Total	836	731	634

Referrals

	Oct-18	Nov-18	Dec-18
NEFHS Providers (refer to footnote 1)	380	310	233
Internal Specialty Providers (refer to footnote 2	832	656	520
Total	1212	966	753
Outstanding NEFHS Providers	0	0	0
Outstanding Int. Speciality Providers	9	1	3
Completed	1203	965	750
Total Requested	1212	966	753



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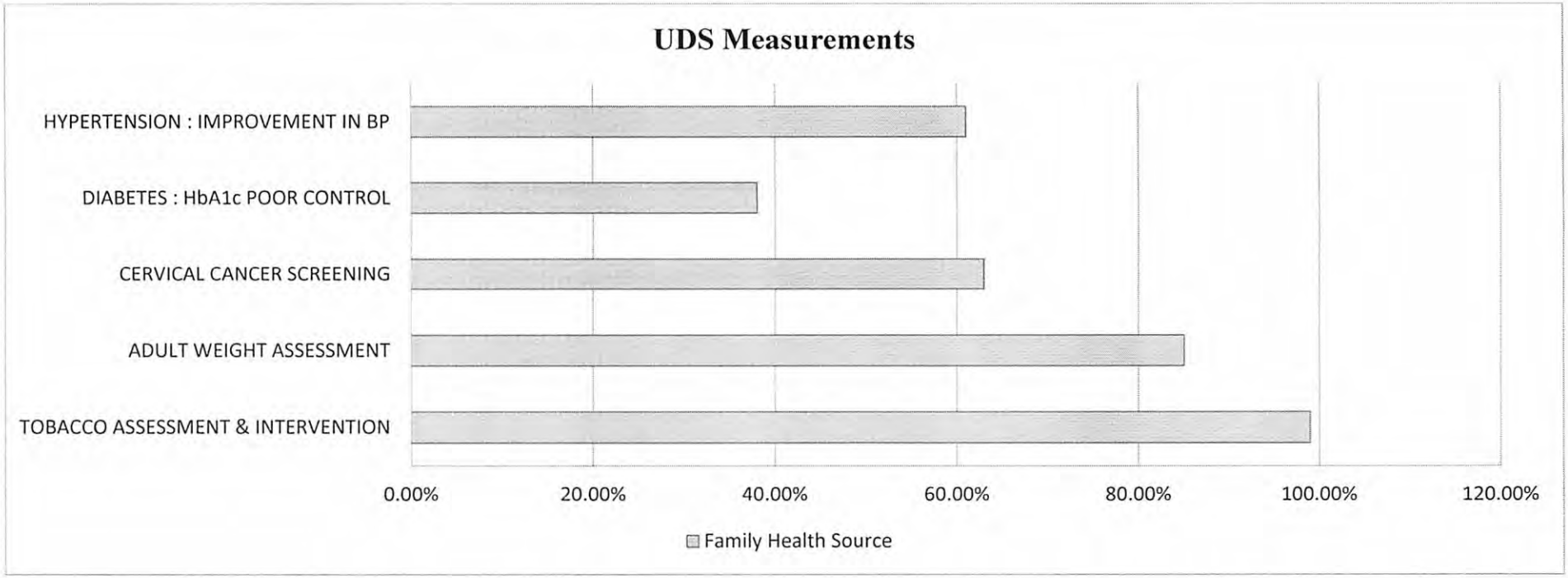
DeLand	Vasanji	Same Day
Deltona	Baldassarre	Same Day
Deltona	Rodriguez	Same Day
Deltona	Macalua	Same Day
Deltona	Mancini	Same Day
Pierson	Roberson	Same Day
Pierson	Kessack	Same Day

UDS Measures

Clinical Measures for the month of October 2017	Family Health
TOBACCO ASSESSMENT & INTERVENTION	99.00%
ADULT WEIGHT ASSESSMENT	85.00%
CERVICAL CANCER SCREENING	63.00%
DIABETES : HbA1c POOR CONTROL	38.00%
HYPERTENSION : IMPROVEMENT IN BP	61.00%



APPLICATION FOR THE WVHA CITIZENS ADVISORY COMMITTEE

NAME: Gloria Osorio

ADDRESS: 3080 Courtland Blvd
Deltona, Fl 32738

HOW LONG HAVE YOU BEEN A WEST VOLUSIA COUNTY RESIDENT: 15 years

HOME PHONE: N/A CELL PHONE: (386) 383-2191

WORK PHONE: same

EMAIL ADDRESS: micasitaalf@yahoo.com

ADDITIONAL INFORMATION (COMMUNITY AFFILIATIONS, EDUCATION, PROFESSIONAL BACKGROUND) THAT YOU FEEL WOULD ASSIST THE BOARD OF COMMISSIONERS IN MAKING A FINAL DETERMINATION:

I attended Oklahoma Christian University. Major: Mass communications (Radio and television)
Minor: Latin American Literature. With Marketing for Electronic media as my emphasis. After years is sales and creating marketing and advertising plans for companies I took time off to care for my father. I realized there was no hispanic anything in west volusia for him at the time and I decided someone had to do it. I developed a unique marketing and business plan and opened Mi Casita Assisted living facility. While working on this project, my husband lost his job and we became Medicaid recipients and at some point we even reached indigent status. We never knew there was a hospital authority. Our goal in creating mi casita ALF was to make sure the least able and most needy received the same or better level of care at the price they were able to pay. Most, if not all of our residents, are SSI recipients.

That would have been my dad had he not had family to care for him to we created in essence, HIS casita. Later we began to take in adult daycare and later Mi casita en tu casita homemaker and companion registry. We provide care to help elderly stay in their homes safely longer. In the midst of this, I was diagnosed with systemic lupus and I was introduced to the affordable care act. My battle has been excruciating and uphill. I have adapted to working from home and with an assistant. Lives are depending on me. I've been at both ends of who you serve and I would like the honor to help in any way I can. As for qualifications:

Founder and administrator of mi casita en tu casita homemaker and companion service

President of Latino Senior Consulting Inc.

Founder and Facility administrator at Mi Casita Alf, Inc.

Executive board member emeritus at Volusia Hispanic chamber of commerce, Inc.

Featured as a Florida Virtual Entreprenuer on FLVEC.com

FHCACA past member (activities directors association)

APPLICATION FOR THE WVHA CITIZENS ADVISORY COMMITTEE

NAME: Julisa Rentas

ADDRESS: 2692 Hibiscus Ct.
Deltona, FL 32738

HOW LONG HAVE YOU BEEN A WEST VOLUSIA COUNTY RESIDENT: 8 years

HOME PHONE: (386) 789-5557 CELL PHONE: (386) 216-1599

WORK PHONE: _____

EMAIL ADDRESS: julisa.rentas@gmail.com

ADDITIONAL INFORMATION (COMMUNITY AFFILIATIONS, EDUCATION, PROFESSIONAL BACKGROUND) THAT YOU FEEL WOULD ASSIST THE BOARD OF COMMISSIONERS IN MAKING A FINAL DETERMINATION:

Graduated Cum Laude B.B.A Marketing from Inter American University of Puerto Rico.

Member of Alpha Phi Omega National Service Fraternity since 1998.

Dreggors, Rigsby & Teal, P.A.
Advisors for Life
Certified Public Accountant | Registered Investment Advisor
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James H. Dreggors, CPA
Ann J. Rigsby, CPA/CFP™
Parke S. Teal, CPA/PFS (1954-2011)

Ronald J. Cantlay, CPA/CFP™
Robin C. Lennon, CPA
John A. Powers, CPA

December 4, 2018

Board of Commissioners
West Volusia Hospital Authority
PO Box 940
DeLand, FL 32720

Re: Community Life Center (CLC) Outreach Services

We have performed the procedures detailed in our engagement letter for grantee site visits, dated January 18, 2018, which were agreed to by West Volusia Hospital Authority (WVHA) Board of Commissioners, solely to assist you with respect to funding agreement compliance of Community Life Center (CLC) Outreach Services for the year ending September 30, 2018. WVHA provides reimbursement of $25.00 per thirty minutes of outreach referral services. The engagement to apply the agreed upon procedures was performed in accordance with the standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below, either for the purpose for which this report has been requested or for any other purpose.

Our procedures and findings are below:

1. Inquire and document as to the grantee's monitoring procedures with respect to contract compliance.

    a. Each month CLC provides to WVHA a list of clients who received services during the prior month. This de-identified list includes the client's city of residence, the date services were rendered, and the units of service billed in thirty minute increments.
    b. CLC determines eligibility by presentation of a photo identification reflecting an address within the WVHA taxing district and/or a completed WVHA Homeless Verification Form from The Neighborhood Center.
    c. CLC multiplies the units of service (typically thirty minutes up to an hour at $25.00 per thirty minutes) to calculate the invoice total.

2. Select a sample of transactions and test compliance with contract provisions.

    a. July, August and September 2018 were chosen for test procedures. A de-identified list of client visits was provided (149 client events).
    b. From the individual list of client visits, ten percent (10%) were selected for compliance review (15 clients). From this list:
        i. CLC provided supporting medical files of all selected clients for review. Fifteen (15) of fifteen (15) or 100% of service dates were verified.
        ii. CLC provided admission forms of all selected clients for review. Each client was not assigned a unique client identification (ID) through CLC's Homeless Management Information System (HMIS); rather, multiple family units were consolidated in one client chart with documentation from one head of household instead of each individual adult. Of the fifteen (15) clients selected there were fifteen (15) admission forms provided or 100%.
        iii. Of the fifteen (15) files sampled, nine (9) files or 60% contained proof of residency. CLC's intake counselors were still mostly only capturing the photo ID of the heads of household.
        iv. Of the fifteen (15) files sampled, nine (9) files or 60% had photo ID's. Of those nine (9) photo ID's, 1 photo ID was not legible; 1 photo ID had a Lake County address; and 1 photo ID had expired in 2005.
        v. Of the fifteen (15) files sampled, twelve (12) files, or 80% were assigned only one unique client ID for multiple family units/members. Of these twelve (12) files, there were multiple units of service billed on the same date for each family member captured under that unique client ID number.

3. Prepare a written report summarizing the results with recommendations to the Board of Commissioners.

    a. The Utilization Report which details clients served and demographic data with respect to those clients, which CLC provides to the WVHA, meets all of the requirements of Section 7 of the funding agreement.
    b. CLC's medical files do not appear to be complete and organized when reviewed for verification of services provided.
    c. CLC's eligibility screening did not meet the requirements of the funding agreement.
    d. Recommend that CLC capture photo ID's from every unique adult client.
    e. Recommend that CLC create a unique client file for each individual adult client and not based upon a family unit.
    f. Recommend that CLC create a unique client ID number for minor children and file the minor child's records with both parents' files, if applicable.
    g. Recommend that DRT return to perform a follow up contractual compliance site visit review for fiscal year 2018-2019.

While performing the contractual compliance site visit, Yvonne Levesque, Operation Manager and Sonaily Mojica, Comptroller, CLC advised that CLC has purchased new software that will allow them to scan and create electronic records and produce more accurate reporting and record keeping. Their intent is to get this new software operational during the month of December 2018.

We were not engaged to, and did not conduct an audit, the objective of which would be the expression of an opinion, on the specified elements, accounts, or items. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the specified users listed above and is not intended to be and should not be used by anyone other than those specified parties.

Dreggors, Rigsby & Teal, P.A.

COMMUNITY *Life* CENTER

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Extension 114

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(407) 324-1616

info@unexpectedkindness.com

www.unexpectedkindness.org

December 4, 2018

Eileen Long
West Volusia Hospital Authority
P.O. Box 940
DeLand, FL 32721-0940

Dear Ms. Long,

Thank you for your time and visit to the Community Life Center offices today. As the audit confirmed, the sampled quarter was prior to many of the updates recently made in the client intake file management system. As we discussed, there have been new checks and balances instated, over the past six months, that were designed to flag any issues with incomplete files in the current analog. Changes have already been implemented in the intake protocol that will resolve many of the issues uncovered in the audit. The most significant update in data management is still being completed in the form of a new cloud-based client management system purchased on July 26, 2018. As of today's date, we have all the hardware in place and have started staff training. This new system will be utilized with each client intake with the analog system already in place and resolve the issues we have experience in the past including giving each person served a unique identifier and flag any file that does not include all requirements. Our timeline for rolling out the new system is as follows; January 3-17, 2019 field testing, July 23, 2019 quality control review and final hardware checks.
Full implementation alongside the current system will be complete by January 31, 2018. When sampling 2019 data, we are confident that you will find everything in order.

We look forward to the next audit.

Grace and peace,

Yvonne Levesque
Operations Manager

Sonaily Mojica
Comptroller

cc: Community Life Center Board of Directors

Dreggors, Rigsby & Teal, P.A.
Advisors for Life
Certified Public Accountant | Registered Investment Advisor
1006 N. Woodland Boulevard ■ DeLand, FL 32720
(386) 734-9441 www.drtcpa.com

James H. Dreggors, CPA
Ann J. Rigsby, CPA/CFP™
Parke S. Teal, CPA/PFS (1954-2011)

Ronald J. Cantlay, CPA/CFP™
Robin C. Lennon, CPA
John A. Powers, CPA

January 17, 2019

To The Board of Commissioners
West Volusia Hospital Authority
P.O. Box 940
DeLand, FL 32720-0940

This letter documents our agreement, as administrators for the West Volusia Hospital Authority, to perform these agreed-upon procedures related to grantee site visits for the fiscal year of 2018-19. The procedures are enumerated below. We will meet with you as needed to discuss the agreed-upon procedures, results, and other issues that may arise.

- Inquire and document as to the grantee's monitoring procedures with respect to contract compliance.
- Select a sample of transaction and test compliance with contract provisions.
- Prepare a written report summarizing the results with recommendations to the Board of Commissioners.

Our engagement to apply agreed-upon procedures will be conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of the procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described above either for the purpose for which this report has been requested or for any other purpose. If, for any reason, we are unable to complete the procedures, we will describe any restrictions on the performance of the procedures in our report, or will not issue a report as a result of this engagement.

Because the agreed-upon procedures listed above do not constitute an examination, we will not express an opinion on financial statements. In addition, we have no obligation to perform any procedures beyond those listed above.

We will submit a report listing the procedures performed and our findings. This report is intended solely for the use of West Volusia Hospital Authority and should not be used by anyone other than this specified party. Our report will contain a paragraph indicating that had we performed additional procedures, other matters might have come to our attention that would have been reported to you. The documentation for this engagement is the property of Dreggors, Rigsby & Teal, P.A. and constitutes confidential information. If requested, access to such attest documentation will be provided under the supervision of Dreggors, Rigsby & Teal, P.A. personnel. Furthermore, upon request, we may provide copies of selected documentation to West Volusia Hospital Authority. West Volusia Hospital Authority may intend, or decide, to distribute the copies or information contained therein to others at their own discretion.

Our fee for these services will be based upon our prevailing standard hourly rates for the particular staff employed.

We appreciate the opportunity to assist you and believe this letter accurately summarizes the significant terms of our engagement. If you have any questions, please let us know. If you agree with the terms of our engagement as described in this letter, please sign the enclosed copy and return it to us. If the need for additional procedures arises, our agreement with you will need to be revised. It is customary for us to enumerate these revisions in an addendum to this letter.

Acknowledged:

Dreggors, Rigsby & Teal, P.A.	West Volusia Hospital Authority	Date

Eileen Long

From: Jacobs, Shawn A <s.jacobs@umr.com>
Sent: Tuesday, December 11, 2018 6:50 PM
To: Eileen Long; 'Ted Small'
Cc: Hibbard, Adam M; Nicoletti, Dominick; Lupo, Donna E
Subject: UMR Report Submission - November Reports to the WVHA Board
Attachments: 12.December. 2018 Board Report v2.pdf; WVHA Subrogation Claim Lien Reduction Request - December 2018.pdf

Eileen per your request, please find UMR's board report submission attached.

Ted please note that the last page of the report indicates a subrogation claim lien reduction request for the board's review and determination. Highlights are as follows:

> POMCO/UMR has been working on a subrogation case regarding a WVHA health card member claims that have confirmed third party liability. In our attempt to recover the funds for WVHA, the heath card member's attorney is requesting that WVHA reduce the liability from $8,776.44 down to $5,000.

Supporting documentation attached separately for the board's review as well.

Let me know if you have any questions.

Thanks.

Regards,
S.A.J.

Shawn A. Jacobs
Strategic Account Executive | UMR
A UnitedHealthcare Company

UMR

shawn.jacobs@umr.com | Tel: **315.937.2790** | Fax: 315.703.4896

***Our* United Culture. The way forward.**
Integrity ▪ Compassion ▪ Relationships ▪ Innovation ▪ Performance

POMCO
EXPERIENCE. EXCELLENCE.

2425 James Street
Syracuse, NY 13206
Telephone: 315.937.2873
Facsimile: 844.690.9209

October 25, 2018

Payas Payas Payas, LLP
1676-B Providence Blvd.
Deltona, FL 32725

VIA FACSIMILE
407-581-8989

Re: West Volusia Hospital Authority Health Plan
Member: [redacted]
Member ID: 891215851
D/A: 5/27/17

To Wom It May Concern:

Enclosed is the updated claims listing relating to the above accident.

Please be advised the West Volusia Hospital Authority Health Plan is self-funded and contains an exclusion for payments received as the result of a "Third Party Claim or Settlement." By definition, a "Third Party Claim" is when you receive payment or are reimbursed as the result of legal action or settlement for services or supplies obtained in connection with an accidental injury. Therefore, the plan must be reimbursed for the expenses it incurs relating to Mr. Riley's accident of May 27, 2017. The plan has paid $8,776.44 to date.

If you need additional information, please contact me.

Sincerely,

Kimberley E. Bigos

Kimberley E. Bigos

/kb

Enclosure

ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement ("Agreement") between UMR, Inc. ("UMR" in this Agreement) and West Volusia Hospital Authority ("Customer" in this Agreement) is effective January 1, 2019 ("Effective Date"). This Agreement covers the services UMR is providing to Customer, either directly or in conjunction with one of UMR's affiliates, for use with Customer's Self-Funded group benefit plan.

UMR, Inc. identifies this arrangement as Contract No.: 76-413413

By signing below, each party agrees to the terms of this Agreement.

West Volusia Hospital Authority 1006 N Woodland Boulevard Deland, FL 32720	**UMR, Inc.** 400 E. Business Way, Suite 100 Cincinnati, OH 45241
By: _____	**By:** _____
Authorized Signature	Authorized Signature
Print Name: _____	**Print Name:** _____
Print Title: _____	**Print Title:** _____
Date: _____	**Date:** _____

Table of Contents

Section 1 – Definitions

When these terms are capitalized in the Agreement they have the meanings set forth below. The words may be singular or plural.

Bank Account: Bank Account maintained for the payment of Plan benefits, expenses, fees and other Customer financial obligations.

Customer: Customer is an independent special tax district encompassing the western portion of Volusia County, Florida (the "District"), created by a special act of the Florida Legislature, Chapter 57-2085, Laws of Florida, as amended (the "Enabling Legislation"), for the purpose of establishing, operating, and maintaining hospitals and other health care facilities for the care of indigents of the District and for pay patients and to participate in other activities to promote the general health of the District.

District: District is an independent special tax district encompassing the western portion of Volusia County, Florida.

IRC: The United States Internal Revenue Code of 1986, as amended from time to time.

IRS: The United States Internal Revenue Service.

Network: The group of Network Providers UMR makes available to the Plan who have entered into or are governed by contractual arrangements under which they agree to provide health care services to Subscribers and accept negotiated fees for these services.

Network Provider: The physician, or medical professional or facility which participates in a Network. A provider is only a Network Provider if they are participating in a Network at the time services are rendered to the Plan Subscriber.

Overpayments: Payments that exceed the amount payable under the Plan. This term does not include overpayments caused by untimely or inaccurate eligibility information.

PHI: Any information UMR receives or provides on behalf of the Plan which is considered Protected Health Information as the term is defined in the privacy regulations of the Health Insurance Portability and Accountability Act of 1996.

Plan: The plan to which this Agreement applies, but only with respect to those provisions of the plan relating to the Self-Funded health benefits UMR is administering, as described in the Summary Plan Description. The plan to which this Agreement applies is not intended to be insurance or a policy of insurance, and therefore, it is the intention of the parties that this Agreement not be subject to the Insurance Law of the State of Florida or the regulations of the Superintendent of Insurance of the State of Florida or to federal insurance laws such as ERISA. Provided, however, that this paragraph shall not act as a waiver of, or prejudice any rights that either of the parties may have under any statute which may be applicable to this Agreement, including the insurance law if legislation is enacted pursuant to which this Agreement would be regulated hereunder.

Plan Administrator: The current or succeeding person, committee, partnership, or other entity designated the Plan Administrator who is generally responsible for the Plan's operation.

Proprietary Business Information: Nonpublic information, trade secrets, and other data including, but not limited to, sales and marketing information, management systems, strategic plans and other information about the disclosing party's business, industry, products and services, plans, specifications, operation methods, pricing, costs, techniques, manuals, know-how and other intellectual property, in written, oral, electronic or other tangible form, provided by one party to another or its representative; and all information, documents, technology, products, and services containing or derived from Proprietary Business Information which was or may have been transmitted, given or made available to or viewed by one party or another in the course of the party's relationship. UMR's Proprietary Business Information includes UMR Financial PBI, as defined in this Section below.

Self-Fund or Self-Funded: Means that Customer, on behalf of the Plan, has the sole responsibility to pay, and provide funds, to pay for all Plan benefits.

Standard of Care: In providing all services set forth in this Agreement, UMR shall use the care, skill, prudence and diligence under the circumstances then prevailing that a prudent claims administrator fiduciary acting in a like capacity and familiar with such matters would use under similar circumstances.

Subscriber: Customer provides access to health care and health care benefits to indigent residents of the District (each, a "Subscriber" and collectively, "Subscribers") who are benefited by the Plan.

Summary Plan Description or SPD: The document(s) Customer provides to Plan Subscribers describing the terms and conditions of coverage offered under the Plan.

Systems: Means the systems UMR owns or makes available to Customer to facilitate the transfer of information in connection with this Agreement.

Tax or Taxes: A charge imposed, assessed or levied by any federal, state, local or other governmental entity.

Term or Term of the Agreement: The period of twelve (12) months commencing on the Effective Date (the "Initial Term") and automatically continuing for additional 12-month periods (each, a "Renewal Term") until the Agreement is terminated.

UMR Financial PBI: UMR's Proprietary Business Information that includes, but is not limited to, discounts and other financial provisions related to UMR's contracted healthcare providers and claims data from which those financial provisions may be derived and financial provisions related to prescription drug products covered under the medical benefit.

Section 2 – Customer Responsibilities

Section 2.1 Responsibility for the Plan. UMR is not the Plan Administrator of the Plan. Any references in this Agreement to UMR "administering the Plan" are descriptive only and do not confer upon UMR anything beyond certain agreed upon claim administration duties. Except to the extent this Agreement specifically requires UMR to have the fiduciary responsibility for a Plan administrative function, Customer accepts total responsibility for the Plan for purposes of this Agreement, including its benefit design, the legal sufficiency and distribution of SPDs, and compliance with any laws that apply to Customer or the Plan, whether or not Customer or someone Customer designates is the Plan Administrator. The Customer represents and warrants that the Plan has the authority to pay fees due under this Agreement from Plan assets.

Section 2.2 Plan Consistent with the Agreement. Customer represents that Plan documents, including the Summary Plan Description as described in Exhibit A – Statement of Work, are consistent with this Agreement. Nevertheless, before distributing any communications describing Plan benefits or provisions to Subscribers or third parties, Customer will provide UMR with such communications which refer to UMR or UMR's services. Customer will amend them if UMR reasonably determines that references to UMR are not accurate, or any Plan provision is not consistent with this Agreement or the services that UMR is providing.

Section 2.3 Plan Changes. Customer must provide UMR with notice of any changes to the Plan and/or Summary Plan Description within a reasonable period of time prior to the effective date of the change to allow UMR to determine if such change will alter the services UMR provides under this Agreement. UMR will notify Customer if (i) the change increases UMR's cost of providing services under this Agreement or (ii) UMR is reasonably unable to implement or administer the change. If the parties cannot agree to a new fee within (30) thirty days of the notice of the new fee, or if UMR notifies Customer that UMR is unable to reasonably implement or administer the change, UMR shall have no obligation to implement or administer the change, and Customer may terminate this Agreement upon (60) sixty days written notice.

Commented [MBarr1]: UMR: In general, this provision reflects the process if you request to make a plan design or service change, we reserve the right to determine if this change would impact the overall pricing and/ or if we can implement.

Section 2.4 Affiliated Employers. [Intentionally left blank; not applicable]

Section 2.5 Information Customer Provides to UMR. Customer, its designated agents or authorized representatives will tell UMR which of Customer's are Subscribers. This information must be accurate and provided to UMR in a

timely manner. UMR will accept eligibility data from Customer in the format described in Exhibit A – Statement of Work. Customer will notify UMR of any change to this information as soon as reasonably possible.

UMR will be entitled to rely on the most current information in UMR's possession regarding eligibility of Subscribers in paying Plan benefits and providing other services under this Agreement. UMR will not be required to make retroactive eligibility changes, or process or reprocess claims based on such retroactive eligibility changes, but if UMR agrees to do so, additional fees may apply.

Customer agrees to provide UMR, in a timely manner with all information that UMR reasonably requires to provide services under this Agreement. UMR shall be entitled to rely upon any written or oral communication from Customer, its designated agents, or authorized representatives.

Section 2.6 Notices to Subscribers. Based on information received from the Customer, UMR shall ~~prepare and distribute to give~~ Subscribers the information and documents they need (Member ID and Member Handbooks) to obtain benefits under the Plan within a reasonable period of time before coverage begins. In the event this Agreement is discontinued, Customer will notify all Subscribers that the services UMR is providing under this Agreement are discontinued.

Section 2.7 Escheat. ~~[Intentionally left blank, not applicable]~~Customer is solely responsible for complying with all applicable abandoned property or escheat laws, making any required payments, and filing any required reports.

Section 3 – Fees

Section 3.1 Fees. Customer will pay fees to UMR as compensation for the services provided by UMR. In addition to the fees specified in Exhibit B - Fees, Customer must also pay UMR any additional fee that is authorized by a provision elsewhere in this Agreement or is otherwise agreed to by the parties.

Section 3.2 Changes in Fees. (a) Following the expiration of the guaranteed Base Medical Fees~~fee guarantee~~ outlined in Exhibit B), UMR can change the fees on each Renewal Term; ~~provided however, UMR agrees to honor its RFP proposal that fees shall increase from $21.55 to $22.09 effective 1/1/2020 and from $22.09 to $22.64 effective 1/1/2021.~~ UMR will provide Customer with thirty (30) days prior written notice of the revised fees for subsequent Renewal Terms. Any such fee change will become effective on the later of the first day of the new Renewal Term or thirty (30) days after UMR provides Customer with written notice of the new fees. UMR will provide Customer with a new Exhibit B - Fees that will replace the existing Exhibit B - Fees for the new Renewal Term.

(b) UMR may also change the fees, if any one or more of the following occur:

(1) any time there are changes made to this Agreement or the Plan, which affect the fees; or

(2) when there are changes in laws or regulations which affect or are related to the services UMR is providing, or will be required to provide, under this Agreement, including the Taxes and fees noted in Section 5 Taxes And Assessments;

Any new fee required by such change will be effective as of the date the changes occur, even if that date is retroactive.

(c) If Customer does not agree to any change in fees, Customer may terminate this Agreement upon thirty (30) days written notice after Customer receives written notice of the new fees. Customer must still pay any amounts due for the periods during which the Agreement is in effect.

Section 3.3 Due Dates, Payments, and Penalties. Customer agrees to pay fees to UMR based on the monthly invoice UMR provides. UMR reserves the right to provide Customer with an estimated invoice for the first month of services. The due date for payment of the invoiced amounts is on the last day of the month for such billing period ("Due Date"). Such invoices are provided on an eligibility-based format, and therefore payment must be made as billed (no adjustments are allowed to the invoice). Adjustments to monthly billing statements for retroactive enrollment or eligibility changes will be performed based on information provided by Customer. Requests for fee adjustment must be made in a timely manner but no more than three (3) months following the date of the change.

Late Payment. If amounts owed are not paid as required when due, Customer will be provided with a notice of default and fifteen (15) days to cure. If Customer does not cure, UMR may terminate this Agreement as provided for in this Agreement. If any portion of the fee is disputed, Customer shall pay UMR the undisputed portion as provided in this

Commented [MBarr2]: UMR: We are agreeable to identifying if we agree to make retroactive eligibility changes that a fee may apply. The intent of this language is not to refuse all retroactive eligibility change requests. When You (our customer) have a few requests, our intent is not to charge for making these changes. However, we do reserve the right to charge for changes that would be onerous or continuous such as change requests for large groups of participants or continual requests for manual correction of eligibility because eligibility information you provide is incorrect and/or overlaying previously made changes.

Commented [MBarr3]: UMR: Per our call, UMR will only distribute this material.

Commented [MBarr4]: UMR: Responsibility for determining the applicability of state escheat/unclaimed property laws to the Plan, and compliance with applicable state escheat/unclaimed property laws, including making any required payments and filing any required reports rests with the Plan. Section A3 Providing Funds for Benefits reflects where we identify uncashed checks to assist you in identifying potential escheat/unclaimed property obligations. However, you (the customer) will need to work with your counsel to determine whether the state escheat/unclaimed property laws impact the Plan and, if not applicable, where those funds will go.

Commented [MBarr5]: UMR: Per call, I inserted language stating this does not apply to the fee guarantees thru 2021.

Commented [MBarr6]: UMR: In 2019, your fees are on a PEPM basis, therefore this applies.

Section 3, and shall provide written details to UMR prior to the date payment is due, explaining Customer's good faith basis for disputing such fee. Customer may withhold the disputed portion during pendency of such dispute, during which time both parties agree to use commercially reasonable efforts to resolve the dispute.

Section 4 – Records, Information, Audits

Section 4.1 Records. UMR shall keep records relating to the services it provides under this Agreement for as long as UMR is required to do so by law.

Section 4.2 Proprietary Business Information. Each party will limit the use of the other's Proprietary Business Information to only the information required to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement. Neither party will disclose the other's Proprietary Business Information to any person or entity other than to the receiving party's employees, subcontractors, or authorized agents needing access to such information to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement, except that UMR's Financial PBI cannot be disclosed by Customer to any third party without UMR's express written consent and, if required by UMR, a mutually agreed upon confidentiality agreement. This provision shall survive the termination of this Agreement.

Section 4.3 Access to Information. Other than as provided for in Section 4.4, if Customer needs access to UMR's Proprietary Business Information, UMR may allow Customer to use UMR's Proprietary Business Information, if it is legally permissible, the information relates to UMR's services under this Agreement, and Customer gives UMR reasonable advance notice and an explanation of the need for such information. Such use is subject to the terms of this Agreement and, if required by UMR, a mutually agreed upon confidentiality agreement.

If Customer is subject to a Freedom of Information Act (FOIA) request and the request includes UMR's Proprietary Business Information, Customer will contact UMR prior to releasing any information and give UMR the opportunity to review, respond, and/or object to the FOIA request.

UMR will provide information only while this Agreement is in effect and for a period of six (6) months after the Agreement terminates, unless Customer demonstrates that the information is required by law or for Plan administration purposes.

UMR also will provide reasonable access to information to an entity providing Plan administrative services to Customer, such as a consultant or vendor, if Customer requests it. Before UMR provides Proprietary Business Information to that entity, the parties must sign a mutually agreed-upon confidentiality agreement, and the parties must agree as to what information is minimally necessary to accomplish the Plan administrative service.

Customer is responsible for entering into any and all legally required agreements with consultant or vendor to ensure protection of the PHI, including but not limited to, a Business Associate Agreement, as defined under the Health Insurance Portability and Accountability Act and its implementing regulations, as amended from time to time.

Section 4.4 Audits. During the term of the Agreement, and at any time within six (6) months following its termination, a mutually agreeable entity may conduct an annual medical claims audit of UMR's performance under the Agreement once each calendar year. Prior to the commencement of this audit, UMR must receive a signed, mutually agreeable confidentiality agreement.

Customer must advise UMR in writing of its intent to audit. The place, time, type, duration, and frequency of all audits must be reasonable and agreed to by UMR. All audits will be limited to information relating to the previous eighteen (18) months.

With respect to UMR's claims processing services, the audit scope and methodology will be consistent with generally acceptable auditing standards, including a statistically valid random sample as approved by UMR ("Scope"). UMR will not support any external audits a) where the audit firm is paid on a contingency basis, and b) that do not use a statistically valid random selection methodology (other than as provided for in this section); this includes electronic/data mining audits that are used for purposes of recovery discovery.

Customer will pay any expenses that it incurs in connection with the audit. In addition, Customer will be charged a reasonable per claim charge and a per day charge for any on-site audit visit that is not completed within five (5) business days or for sample sizes exceeding the Scope specified above. The additional fees cover the additional resources, facility fees, and other incremental costs associated with an audit that exceeds the Scope.

In addition to Customer's expenses and any applicable fees, Customer will also pay any extraordinary expenses UMR incurs due to a Customer request related to the audit, such fees to be reviewed and approved by the Customer in advance. For any audit initiated after this Agreement is terminated or for any audit in addition to those provided for in this Section (if approved by UMR), Customer will pay all expenses incurred by UMR.

Customer will provide UMR with a copy of any audit reports within thirty (30) days after Customer receives the audit report(s) from the auditor.

Section 4.5 Service Auditor Reports. UMR may make its Type II service auditor report ("Report") available to UMR's self-funded customers each year for Customer's review in connection with Plan administrative purposes only. The Report will be issued under the guidance of Statement on Standards for Attestation Engagements #16 (SSAE18). Should new guidelines covering service auditor reports be issued, UMR may make the equivalent of, or any successor to, the SSAE18 Type II Report available to UMR's self-funded customers. The Report is UMR's Proprietary Business Information and shall not be shared with any third parties without UMR's prior written approval, except that Customer can share the Report with: (i) Customer's independent public accounting firm; and/or (ii) Customer's consultants on the condition that such consultants are not in any way a competitor of UMR's and that Customer informs its consultants that the Report was not prepared for their use. To the extent that Customer does provide the Report to its independent public accounting firm or a consultant as permitted in this Section, Customer shall require that they retain the Report as confidential and that they not disclose such Report to any other persons or entities.

Section 4.6 PHI. The parties' obligations with respect to the use and disclosure of PHI are outlined in the Business Associate Addendum attached to this Agreement.

Section 5 – Taxes And Assessments

Section 5.1 Payment of Taxes and Expenses. In the event that any Taxes are assessed against UMR as a claim administrator in connection with UMR's services under this Agreement, including all topics identified in Section 5.3 Customer will reimburse UMR through the Bank Account for Customer's proportionate share of such Taxes (but not Taxes on UMR's net income). UMR has the authority and discretion to reasonably determine whether any such Tax should be paid or disputed. Customer will also reimburse UMR for a proportionate share of any cost or expense reasonably incurred by UMR in disputing such Tax, including costs and reasonable attorneys' fees and any interest, fines, or penalties relating to such Tax, unless caused by UMR's unreasonable delay or unreasonable determination to dispute such Tax, and provided UMR consults with Customer in advance of disputing such Tax in a manner consistent with UMR's fiduciary obligations.

Section 5.2 Tax Reporting. In the event that the reimbursement of any benefits to Subscribers in connection with this Agreement is subject to Plan or employer based tax reporting requirements, Customer agrees to comply with these requirements.

Section 5.3 State and Federal Surcharges, Fees and Assessments. The Plan is responsible for state or Federal surcharges, assessments, or similar Taxes imposed by governmental entities or agencies on the Plan or UMR, (but not Taxes on UMR's net income), including, but not limited to, those imposed pursuant to The Patient Protection and Affordable Care Act of 2010 ("PPACA"), as amended from time to time. This includes the funding, remittance, and determination of the amount due for PPACA required taxes and fees.

Section 6 – Indemnification

Section 6.1 Customer Indemnifies UMR. Nothing in this section or Agreement shall operate to waive, limit, or alter in any way the sovereign immunity of Customer or UMR to the extent such immunity is available under Florida law. (a) Without waiver of any applicable sovereign immunity, Customer will indemnify UMR and hold UMR harmless against any and all losses, liabilities, penalties, fines, costs, damages, and expenses that UMR incurs, including reasonable attorneys' fees and costs, which arise out of:

(1) Customer or its vendors', subcontractors' or authorized agents' gross negligence or willful misconduct, ~~failure to comply with any laws, statutes, ordinances or regulations, negligent act or omission~~ in the performance of (A) Customer's or its vendors', subcontractors, or authorized agents' obligations under this Agreement, ~~or~~ (B) Customer's or its vendors', subcontractors', or authorized agents' material breach~~performance~~ under any other agreements entered into by UMR with ~~those~~ third parties on Customer's behalf as directed by the Customer.

Commented [MBarr7]: UMR: per request, to add the below language, we cannot agree as section 7.4 is unrelated to Section 5.1.

"Subject to UMR's compliance with the advance notice and consultation provision of Section 7.4"

Commented [MBarr8]: UMR: Per call, we proposed language for your review.

Commented [MBarr9]: UMR: per call, agreeable to add verbiage

Commented [MBarr10]: UMR: We are not referring to Plan specific taxes; it is addressing taxes assessed on our self-funded book of business situsted within the taxing authority's jurisdiction. We are seeking reimbursement from the customer in the event a state in the future tries to assess a premium type or similar tax on ASO fees, on benefits paid, or some other basis related to the ASO Agreement and the services we perform under the Agreement for the customer.
We need the flexibility to make the final decision on disputing such tax because we have to make one global decision on behalf of all our ASO customers in the particular state.

Commented [MBarr11]: UMR Response: Per call, we have reviewed and while we cannot agree to a simple negligence, we will agree to a Standard of Care. Refer to Definitions Section 1.

(2) Customer's material breach of (A) this Agreement, or (B) any other agreements entered into by UMR with third parties on Customer's behalf as directed by the Customer;

(3) A material breach by a third party of any other agreements UMR enters into with such third parties on Customer's behalf as directed by the Customer; and

(4) Unless Customer has proven UMR's failure to meet the Standard of Care, third party claims brought against UMR as the claims administrator (e.g. a claim raised by the federal government based on the federal Medicare Secondary Payor laws.

(b) If the parties are unable to mutually resolve the matter, or are unable to resolve it through mediation, the indemnification obligations set forth in this Section are enforceable against Customer only as determined by a court or other tribunal having jurisdiction of the matter.

(c) This provision shall survive the termination of this Agreement.

Section 6.2 UMR Indemnifies Customer. (a) UMR will indemnify Customer and hold Customer harmless against any and all losses, liabilities, penalties, fines, costs, damages, and expenses, that Customer incurs, including reasonable attorneys' fees and costs, which arise out of:

(1) UMR or its vendors', subcontractors' or authorized agents' failure to meet the Standard of Care ~~gross negligence or willful misconduct, failure to comply with any laws, statutes, ordinances or regulations, negligent act or omission~~ in the performance of UMR or its vendors', subcontractors' or authorized agents' obligations under this Agreement. Notwithstanding the foregoing, UMR's obligation to indemnify Customer for Overpayments shall be governed exclusively by Section A2 Recovery Services of this Agreement.; and

(2) UMR's material breach of this Agreement.

(b) If the parties are unable to mutually resolve the matter, or are unable to resolve it through mediation, the indemnification obligations set forth in this Section are enforceable against UMR only as determined by a court or other tribunal having jurisdiction of the matter.

(c) Customer will remain responsible for payment of benefits and UMR's indemnification will not extend to indemnification of Customer or the Plan against any claims, liabilities, damages, judgments, or expenses that constitute payment of Plan benefits.

(d) This provision shall survive the termination of this Agreement.

Section 7 – Plan Benefits Litigation

Section 7.1 Litigation Against UMR. If a demand is asserted, or litigation or administrative proceedings are begun by a Subscriber or healthcare provider against UMR to recover Plan benefits related to its duties under this Agreement ("Plan Benefits Litigation"), UMR will select and retain defense counsel to represent its interest.

Section 7.2 Litigation Against Customer. If Plan Benefits Litigation is begun against Customer and/or the Plan, Customer will select and retain counsel to represent its interest.

Section 7.3 Litigation Against UMR and Customer. If Plan Benefits Litigation is begun against the Plan and UMR jointly, and provided no conflict of interest arises between the parties, the parties may agree to joint defense counsel. If the parties do not agree to joint defense counsel, then each party will select and retain separate defense counsel to represent their own interests.

Section 7.4 Litigation Fees and Costs. ~~Each party shall pay their own fees and costs except as provided in Section 6.2.~~ All reasonable legal fees and costs UMR incurs will be paid by Customer (except as provided in Section 6.2) if UMR gives Customer reasonable advance notice of UMR's intent to charge Customer for such fees and costs, and UMR consults with Customer in advance ~~of pursuing~~of pursuing such Plan Benefit Litigation in a manner consistent with UMR's fiduciary obligations on UMR's litigation strategy.

Commented [MBarr12]: UMR: Per call, we proposed language for your review.

Section 7.5 Litigation Cooperation. Both parties will cooperate fully with each other in the defense of Plan Benefits Litigation.

Section 7.6 Payment of Plan Benefits. In all events, Customer is responsible for the full amount of any Plan benefits paid as a result of Plan Benefits Litigation.

Section 7.7 Survival. This provision shall survive the termination of this Agreement.

Section 8 – Mediation

Except in the case of UMR's termination due to Customer's failure to provide funds for benefits or fees, in the event that any dispute, claim, or controversy of any kind or nature relating to this Agreement arises between the parties, the parties agree to meet and make a good faith effort to resolve the dispute. If the dispute is not resolved within thirty (30) days after the parties first met to discuss it, and either party wishes to pursue the dispute further, that party will refer the dispute to non-binding mediation under the Commercial Mediation Rules of the American Arbitration Association ("AAA"). In no event may the mediation be initiated more than one year after the date one party first gave written notification of the dispute to the other party. A single mediator engaged in the practice of law, who is knowledgeable about benefit plan administration, will conduct the mediation under the then current rules of the AAA. The mediation will be held in a mutually agreeable site. Nothing in this Section is intended to prevent either party from seeking any other remedy available at law including seeking redress in a court of competent jurisdiction. This provision shall survive the termination of this Agreement.

Section 9 – Termination

Section 9.1 Services End. UMR's services under this Agreement stop on the date this Agreement terminates, regardless of the date that claims are incurred. However, UMR may agree to continue providing certain services beyond the termination date, as provided in Exhibit A – Statement of Work.

Section 9.2 Termination Events. This Agreement will terminate under the following circumstances:

(1) The Plan terminates;

(2) Both parties agree in writing to terminate the Agreement;

(3) After the Initial Term, either party gives the other party at least sixty (60) days prior written notice;

(4) UMR gives Customer notice of termination pursuant to Section 3.3 because Customer did not pay the fees or other amounts Customer owed UMR when due under the terms of this Agreement ~~as set forth in Section 3.3, and Customer does not correct the breach within thirty (30) days of being notified in writing by UMR~~;

Commented [MBarr13]: UMR Response: per call, proposed language for review.

(5) UMR gives Customer notice of termination if Customer fails to provide the required funds for payment of benefits under the terms of this Agreement, and Customer does not correct the breach within thirty (30) days of being notified in writing by UMR;

(6) Either party is in material breach of this Agreement, other than by non-payment or late payment of fees owed by Customer or the funding of Plan benefits, and does not correct the breach within thirty (30) days after being notified in writing by the other party;

(7) UMR may terminate this Agreement in the event of a filing by or against the Customer of a petition for relief under the Federal Bankruptcy Code;

(8) Any state or other jurisdiction prohibits a party from administering the Plan under the terms of this Agreement, or imposes a penalty on the Plan or UMR and such penalty is based on the administrative services specified in this Agreement. In this situation, the party may immediately discontinue the Agreement's application in such state or jurisdiction. Notice must be given to the other party when reasonably practical. The Agreement will continue to apply in all other states or jurisdictions; or

(9) As otherwise specified in this Agreement.

Section 10 – Miscellaneous

Section 10.1 Subcontractors. UMR can use its affiliates or subcontractors to perform UMR's services under this Agreement. UMR will be responsible for those services to the same extent that UMR would have been had it performed those services without the use of an affiliate or subcontractor.

Section 10.2 Assignment. Except as provided in this paragraph, neither party can assign this Agreement or any rights or obligations under this Agreement to anyone without the other party's written consent. That consent will not be

unreasonably withheld. Nevertheless, UMR can assign this Agreement, including all of its rights and obligations to UMR's affiliates, to an entity controlling, controlled by, or under common control with UMR, or a purchaser of all or substantially all of UMR's assets, subject to notice to Customer of the assignment.

Section 10.3 Governing Law. This Agreement is governed by the applicable laws of the State of Florida. This provision shall survive the termination of this Agreement.

Section 10.4 Entire Agreement. This Agreement, with its exhibits, constitutes the entire agreement between the parties governing the subject matter of this Agreement. This Agreement replaces any prior written or oral communications or agreements between the parties relating to the subject matter of this Agreement. The headings and titles within this Agreement are for convenience only and are not part of the Agreement.

Section 10.5 Amendment. Except as may otherwise be specified in this Agreement, the Agreement may be amended only by both parties agreeing to the amendment in writing, executed by a duly authorized person of each party.

Section 10.6 Waiver/Estoppel. Nothing in this Agreement is considered to be waived by any party, unless the party claiming the waiver receives the waiver in writing. No breach of the Agreement is considered to be waived unless the non-breaching party waives it in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of this Agreement, or to exercise any option which is provided in this Agreement, will in no way be construed to be a waiver of such provision of this Agreement.

Section 10.7 Notices. Any notices, demands, or other communications required under this Agreement will be in writing and ~~may~~ shall be provided both via electronic means ~~or~~ and by United States Postal Service by certified or registered mail, return receipt requested, postage prepaid, or delivered by a service that provides written receipt of delivery.

Commented [MBarr14]: UMR: Per call, we agreed to change to "and".

Section 10.8 Use of Name. The parties agree not to use each other's name, logo, service marks, trademarks or other identifying information without the written permission of the other, except that Customer grants UMR permission to use Customer's name, logo, service marks, trademarks or other identifying information to the extent necessary for UMR to carry out its obligations under this Agreement (e.g. on SPDs and ID cards).

Section 10.9 Compliance with Laws and Regulations. The parties agree to comply with all applicable federal, state and other laws and regulations with respect to this Agreement.

Section 10.10 No Third Party Beneficiaries. Nothing in this Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

Section 10.11 Severability. The invalidity or unenforceability of any provision of this Agreement will not affect the validity or enforceability of any other provision. However, it is intended that a court of competent jurisdiction construe any invalid or unenforceable provision of this Agreement by limiting or reducing it so as to be valid or enforceable to the extent compatible with applicable law.

Section 10.12 Acceptance. Following the Effective Date, this Agreement is deemed executed by the parties.

Section 10.13 Insurance Requirements. The selected firm, if any, shall maintain, at all times, the following minimum levels of insurance and; shall, without in any way altering their liability, obtain, pay for and maintain insurance for the coverages and amounts of coverage not less than those set forth below. Provide to the WVHA original Certificates of Insurance satisfactory to the WVHA to evidence such coverage before any work commences. The WVHA shall be named as an additional insured on all policies related to the project; excluding workers' compensation and professional liability. The policies shall contain a waiver of subrogation as against WVHA; excluding professional liability. All insurance coverage shall be written with a company having an A.M. Best Rating of at least the "A" category and size category of VIII. ~~The firm's self-insured retention or deductible per line of coverage shall not exceed $25,000 without the permission of the WVHA.~~ The WVHA requires 30 days written notice of cancellation and 15 days written notice of non-payment. In the event of any failure by the firm to comply with the provisions; the WVHA may, at its option, on notice to the firm suspend the project for cause until there is full compliance. Alternatively, the WVHA may purchase such insurance at the firm's expense, provided that the WVHA shall have no obligation to do so and if the WVHA shall do so, the firm shall not be relieved of or excused from the obligation to obtain and maintain such insurance amounts and coverages.

Commented [jlh15]: UMR: Our professional liability carrier will not waive their rights.

Commented [jlh16]: UMR: We consider our self-insured retentions and deductibles to be confidential and they often exceed $25K.

Worker's Compensation and Employer's Liability Insurance providing statutory benefits, including those that may be required by any applicable federal statute:

Admitted in Florida	Yes
Employer's Liability	$100,000
All States Endorsement	Statutory
Voluntary Compensation	Statutory

Commercial General Liability Insurance. $1,000,000 combined single limit of liability for bodily injuries, death, and property damage, and personal injury resulting from any one occurrence, including the following coverages:

Premises and Operations:
Broad Form Commercial General Liability ~~Endorsement~~ to include ~~blanket~~ contractual liability ~~(specifically covering, but not limited to, the contractual obligations assumed by the Firm)~~; Personal Injury ~~(with employment and contractual exclusions deleted)~~ and Broad Form Property Damage coverages;
Independent Contractors;

Commented [jlh17]: UMR: We have the standard current ISO GL form. It includes the current contractual liability coverage give-back, however this does not tie specifically to what has been agreed to in another contract. We also do not have the employment and contractual exclusions deleted.

Independent Contractors:
Delete Exclusion relative to Collapse, Explosion and Underground Property Damage Hazards; and Cross Liability Endorsement.

Comprehensive Automobile Liability Insurance. $1,000,000 combined single limit of liability for bodily injuries, death, and property damage, and personal injury resulting from any one occurrence, including all owned, hired and non-owned vehicles.

Professional Liability Insurance. $1,000,000 for design errors and omissions, exclusive of defense costs. Selected firm shall be required to provide continuing Professional Liability Insurance to cover the project for a period of two (2) years after the projects are completed.

EXHIBIT A – STATEMENT OF WORK

The following are the administrative services UMR has agreed to provide to Customer. Customer may request that UMR provide services in addition to those set forth in this Agreement. If UMR agrees to provide them, those services will be governed by the terms of this Agreement and any amendments to this Agreement. Customer will pay an additional fee, determined by UMR, for these additional services. The services described in this Exhibit will be made available to Customer's eligible Subscribers consistent with the Summary Plan Description under which the Subscriber covered.

Section A1 Network

Network Access, Management and Administration. UMR will provide access to Networks and Network Providers, as well as related administrative services including physician (and other health care professional) relations, clinical profiling, contracting and credentialing, and network analysis and system development. The make-up of the Network can change at any time. Notice will be given in advance or as soon as reasonably possible.

UMR generally does not employ Network Providers and they are not UMR's agents or partners, although certain Network Providers are affiliated with UMR. Otherwise, Network Providers participate in Networks only as independent contractors. Network Providers and the Subscribers are solely responsible for any health care services rendered to Subscribers. UMR is not responsible for the medical outcomes or the quality or competence of any provider or facility rendering services, including Network Pharmacies and services provided through UMR's affiliates' networks, or the payment for services rendered by the provider or facility.

Section A2 Recovery Services

Claim Recoveries. In the event an Overpayment is made, UMR shall make an attempt to recover Overpayments using its Overpayment recovery procedures. In the event the recovery attempts are unsuccessful, UMR will follow its established overpayment recovery rules for an escalated recovery process. Recovery attempts will remain open for a minimum of twelve months. UMR will be responsible for reimbursement of any unrecovered Overpayment to the extent the Overpayment was due to UMR's failure to meet the Standard of Care ~~gross negligence~~.

Customer will be charged fees for the services described in this Section provided by UMR through a subcontractor or affiliate, or as negotiated in advance with Customer. The fees are deducted from the actual recoveries. Customer will be credited with the net amount of the recovery.

Claim Recovery Process. Customer delegates to UMR the discretion and authority to develop and use standards and procedures for any recovery, including but not limited to, whether or not to seek recovery, what steps to take if UMR decides to seek recovery, and the circumstances under which a claim may be compromised or settled for less than the full amount of the claim. Customer acknowledges that use of UMR's standards and procedures may not result in full or partial recovery for any particular case. UMR will not pursue any recovery if it is not permitted by any applicable law, or if recovery would be impractical.

If this Agreement terminates, or, if UMR's claim recovery services terminate, UMR can continue to recover any payments UMR is in the process of recovering. The appropriate fees will continue to be deducted from the actual recovery, when and if a recovery is obtained.

Fraud and Abuse Management. UMR's Special Investigation Unit reviews and investigates potentially fraudulent or inappropriate billings submitted by providers and Subscribers. Following investigation, the identified Claims are either paid in accordance with the Plan, or are denied for such reasons as are uncovered by the Special Investigation Unit. Fraud and Abuse Management processes will be based upon UMR's proprietary and confidential procedures, modes of analysis and investigations.

UMR will use these procedures and standards in delivering Fraud and Abuse Management services to Customer and UMR's other customers. These procedures and standards include, but are not limited to: whether or not to seek recovery, what steps to take if UMR decides to seek recovery, and under what circumstances to compromise a claim or settle for less than the full amount.

~~Customer authorizes delegates to UMR the discretion and authority~~ UMR to follow ~~use such~~ procedures and standards, including the authority to undertake actions, including legal actions, which have the largest impact for the largest number of customers. Customer acknowledges that the use of these procedures and standards may not result in full or partial recovery or in full recovery for any particular case. UMR does not guarantee or warranty any particular level

Commented [MBarr18]: UMR: To restore as originally written

of prevention, detection, or recovery. UMR agrees to perform Fraud and Abuse Management services pursuant to the industry standards for such services. If this Agreement terminates, or if UMR's claim recovery services terminate, UMR can elect to continue fraud and abuse recoveries that are in progress and the fees will continue to apply.

Commented [MBarr19]: UMR: Revised this section to reflect your set up in 2019.

Section A3 Providing Funds for Benefits

Responsibility. The Plan is Self-Funded. Customer is solely responsible for providing funds for payment for all Plan benefits payable to Subscribers, Network Providers, or non-Network Providers. UMR has no liability or responsibility to provide these funds.

Control of Plan Assets. In the event that the Plan is found to have Plan assets, the Customer shall have absolute authority with respect to such Plan assets, and UMR shall neither have nor be deemed to exercise any discretion, control or authority with respect to the disposition of Plan assets.

Bank Account. UMR has agreed to establish a Bank Account on behalf of Customer, in Customer's UMR's name and tax identification number. The Bank Account is set up in a manner so that banking fees are offset for Customer in lieu of earning interest. UMR, shall be given the necessary nonexclusive authority to utilize funds in the Bank Account for payment of Plan benefits, Plan expenses (such as state surcharges or assessments), and other agreed upon services under the Agreement.

Services. UMR shall be responsible for the performance of Bank Account reconciliation. UMR agrees to send search letters to payees of uncashed checks in accordance with UMR's established procedures. Uncashed checks will be returned to the Plan as soon as reasonably possible after search efforts have ceased. In no event shall UMR become a holder of unclaimed property, as defined in any applicable unclaimed property law.

~~**Security Deposit.** Customer agrees to a security deposit in an amount determined by UMR. UMR reserves the right to require adjustments of the security deposit based on actual average disbursement activity. The security deposit is to cover periodic fluctuations in claim activity and must remain in the account as long as UMR continues to issue payments against the account. UMR agrees to return the balance of the security deposit to Customer as soon as reasonably possible after the Bank Account is closed.~~

Payment Authorization. Authorization to release payments drawn on Customer's UMR's Bank Account will be provided by UMR once Customer's funding obligations have been met. UMR offers various frequencies for the printing and release of checks and electronic payments. If a month-end clear option is applied, that means any payments held in queue at the end of the month will be released on the last working day of the month. UMR will provide weekly reports regarding cash disbursements to Customer.

Timing. Customer shall make bi-monthly reimbursements of the account via check.

~~**Account Balance.** In the event Customer's Bank Account balance falls below fifty percent (50%) of the security deposit amount, UMR reserves the right to either initiate an ACH for disbursements not funded or UMR will contact Customer and request Customer wire transfer needed funds to Bank Account. In the event the Bank Account balance falls below twenty five percent (25%) of the security deposit, UMR reserves the right to suspend payment of claims under Customer's Plan(s). Payment of such claims will be restored when UMR has been reimbursed for all outstanding disbursements and the security deposit has been restored. In the event the disbursement activity creates a deficit in the account, UMR will immediately notify Customer. A same day wire deposit to Customer's Bank Account must be made to fund all unpaid Claims and to restore the security deposit amount. Customer agrees to pay overdraft charges, when applicable, related to the maintenance of the Bank Account. UMR will maintain the Bank Account for a period of one hundred eighty (180) days after the last check is cut or one hundred eighty (180) days after the date of the oldest outstanding check. Customer is responsible for paying UMR the monthly banking maintenance fee as set forth in Exhibit B - Fees for as long as the account remains open.~~

Pre-Authorized Check Release. Customer has requested that UMR implement a Pre-Authorized Check Release service for the Plan, under which Customer retains authority to authorize release of checks for Plan benefits, subject to the following provisions:

(i) UMR will notify Customer, on a weekly basis, of the total listing of checks for all approved claims for which UMR has assigned a check number and issued an Explanation of Benefits and which are ready for release.

(ii) Customer is responsible for reviewing and authorizing UMR to release the checks as soon as reasonably possible, but no later than fourteen (14) calendar days from the issue date of the checks.

(iii) In the event that UMR has not received written approval from Customer to release the checks within fourteen (14) calendar days from the issue date of the checks, Customer understands and agrees that UMR reserves the right to release the checks automatically and that Customer is obligated to have sufficient funds in its bank account to cover the checks.

(iv) Customer acknowledges that there could be legal, regulatory compliance and monetary risks that may result from Pre-Authorized Check Release, including, but not limited to: loss of negotiated network discounts or other price abatements with providers of medical care, including physicians and hospitals; loss of coverage for claims under stop loss or excess loss policies due to the failure to make claim payments consistent with policy requirements and/or within prescribed timeframes; and liability for breach of fiduciary duty under applicable law for failure to make required Claim payments.

(v) Indemnification. Customer (and its successors and assigns) agree to waive, discharge and release UMR and to hold it harmless against any claim, cause of action, injury, compensation, and/or damages, including any claim for lost discounts, stop loss reimbursements, debts, costs, judgments, fines, penalties, attorneys' fees and other costs of litigation, directly or indirectly related to or arising out of the use of Pre-Authorized Check Release by Customer or the Plan. Customer agrees that this indemnification extends to all claims of every nature and kind that may arise related to Pre-Authorized Check Release.

Section A4 System Access

Access. UMR grants Customer the nonexclusive, nontransferable right to access and use the functionalities contained within the Systems, under the terms specified in this Agreement. Customer agrees that all rights, title, and interest in the Systems and all rights in patents, copyrights, trademarks, and trade secrets encompassed in the Systems will remain UMR's. To obtain access to the Systems, Customer will obtain, and be responsible for maintaining, at no expense to UMR, the hardware, software, and Internet browser requirements UMR provides to Customer, including any amendments thereto. Customer will be responsible for obtaining an Internet Service Provider or other access to the Internet. Customer will not (i) access Systems or use, copy, reproduce, modify, or excerpt any Systems documentation provided by UMR in order to access or utilize Systems, for purposes other than as expressly permitted under this Agreement or (ii) share, transfer or lease Customer's right to access and use Systems, to any other person or entity which is not a party to this Agreement. Customer may designate any third party, with prior approval from UMR, to access Systems on Customer's behalf, provided the third party agrees to these terms and conditions of Systems access and Customer assumes joint responsibility for such access.

Security Procedures. Customer will use commercially reasonable physical and software-based measures to protect the passwords and user IDs provided by UMR for access to and use of any web site provided in connection with the services. Customer shall use commercially reasonable anti-virus software, intrusion detection and prevention system, secure file transfer and connectivity protocols to protect any email and confidential communications provided to UMR, and maintain appropriate logs and monitoring of system activity, Customer shall notify UMR within a reasonable timeframe of any (a) unauthorized access or damage, including damage caused by computer viruses resulting from direct access connection, and (b) misuse and/or unauthorized disclosure of passwords and user IDs provided by UMR which impact the System.

Termination. UMR reserves the right to terminate Customer's System access (i) on the date Customer fails to accept the hardware, software and browser requirements provided by UMR, including any amendments thereto or (ii) immediately on the date UMR reasonably determines that Customer has (i) breached, or allowed a breach of, any applicable provision of this Section or (ii) materially breached or allowed a material breach of, any other applicable provision of this Agreement. Customer's System Access will also terminate upon termination of this Agreement, except that if run-out is provided in accordance with Exhibit A - Statement of Work, Customer may continue to access applicable functionalities within the Systems during the run-out period. Upon any of the termination events described in this Agreement, Customer agrees to cease all use of Systems, and UMR will deactivate Customer's identification numbers, passwords, and access to the System.

Schedule of Services

A. Claims Administration Services

Service	Comments
Claims for Plan benefits must be submitted in a form that is satisfactory to UMR in order for UMR to determine whether a benefit is payable under the Plan's provisions. Customer delegates to UMR the discretion and authority to use UMR's claim procedures and standards for Plan benefit claim determination.	
Implementation of Customer's benefit plans and payment of claims.	UMR will process only those claims which are incurred on or after the Effective Date of this Agreement, except as otherwise agreed to by the parties for claims run-in services. ~~The parties agree that claims run-in services shall be processed according to the terms of their prior Administration Agreement dated January 1, 2016, as amended~~Run-in services are subject to the following provisions:
Standard claims processing including: • Re-pricing and payment of claims. • Auto and manual adjudication using proprietary software. • Provide an Explanation of Benefits (EOB) notice to Subscribers and Remittance Advice (RA) statement to providers as required • Prepare and mail 1099's to providers and other vendors, using UMR's name and tax identification number.	In the event that Customer asks UMR to load data from the prior TPA regarding Subscriber's benefit accumulators, UMR will have no obligation to verify the accuracy of such data.
Standard coordination of benefits for all claims	UMR pays claims for Medicare-eligible persons as either primary or secondary, based on the Medicare Secondary Payor Rules.
Claims Run-Out Services. UMR will process all claims received up to the date of termination of this Agreement. Any unprocessed claims will be denied, unless Customer requests claims run-out services (unprocessed claims incurred prior to the termination date) at a mutually agreed upon fee prior to the termination of this Agreement. In the event that UMR receives claims after the run-out period expires, then UMR will deny the claim.	If the Agreement terminates because Customer fails to pay UMR fees due, fails to provide the funding for the payment of benefits, or UMR terminates for any other material breach, run-out will not apply. **Suspension of Run-out Processing** If Customer does not pay the run-out fees it owes UMR when due as set forth above, UMR will notify Customer. If Customer does not make the required payment UMR may stop issuing checks and non-draft payments and suspend its run-out claims processing under this Agreement, such suspension to apply to all claims regardless of dates of service and shall remain in effect until such date when Customer makes the required payment. **Termination of Run-out Processing** Run-out claims processing will terminate if Customer fails to provide the required funds for payment of benefits under the terms of this Agreement. Such termination shall apply to all claims regardless of dates of service.
Foreign service procedures	[Intentionally left blank; not applicable]
State Surcharges. If during the term of the Agreement UMR receives a surcharge invoice from a state for the Plan or claims paid under the Plan, UMR agrees to submit applicable payments to the state on behalf of Customer. The amount due to the state will be withdrawn from Customer's claims bank account.	This service does not apply to New York Surcharges.

Commented [MBarr20]: UMR: Confirmed, as of 2019 with the migration complete, run- in does not apply.

Commented [MBarr21]: UMR: Refer to response in Section 5.

Service	Comments
Claim Reprocessing. Customer requests to reprocess certain claims.	No fee is charged for claims being reprocessed in connection with an error made by UMR. A fee is charged for claims being reprocessed: a) as a result of retroactive benefit or eligibility changes that Customer made or in connection with other actions by Customer, its employees or agents, or b) if Customer contracts directly with a provider network and that provider network gives UMR incorrect or late fee or other provider information that necessitates adjustment of claims.

B. MEMBER SERVICES

Service	Comments
Toll-free access to a customer care unit	
Subscriber access to a member website enabling Subscribers to: • Check claim status. • Check eligibility information. • Search for providers and online health information.	
Identification Cards. UMR will provide standard ID cards (including replacement cards) for each employee who is covered under Customer's Plan.	Customer may, at its option, order customized ID cards at an additional cost.

C. Customer Reporting Services

Service	Comments
UMR will provide Customer with the following standard reports through encrypted online access.	
Banking. Online access to the check register, searchable for disbursement information at the transaction level.	
Monthly Online Reports (Plan Performance). Online access to monthly reports containing Plan performance details. Customer can also use online data to develop ad-hoc queries such as census information, claim activity and large claim detail.	
Eligibility and Benefits Inquiry. Online eligibility inquiry provides Customer with access to Subscriber eligibility information. Online benefit inquiry provides specific benefit information for each Subscriber.	
Claims Inquiry. Customers can review the status of Subscriber claims online. Customer is responsible for ensuring that its employees comply with HIPAA privacy regulations.	
Customization, non-standard or ad hoc reports	Fees are determined on a report-specific basis
UMR reserves the right, from time to time, to change the content, format and/or type of UMR's reports.	

D. Other Services

Service	Comments
Summary Plan Description (SPD) Assistance. UMR will prepare a customized draft of an SPD for the Plan, one additional draft, in response to Customer's comments and a final draft SPD.	If the SPD is not finalized sufficiently in advance of the Effective Date of UMR's services, UMR will utilize benefits and exclusions that UMR has created based on its understanding of Customer's Plan design and which Customer has reviewed and approved UMR will administer claims and otherwise provide UMR's services in accordance with information and it will govern and remain in full force and effect until a final SPD is provided to UMR.
SPD Exception Processing. In the event Customer wants UMR to make an exception to Customer's Summary Plan Description (SPD), Customer must notify UMR in writing of such exception using a form designated by UMR. Customer is fully and solely responsible for any compliance or stop loss issues that may occur as a result of making an exception to its SPD.	UMR shall not be liable to any degree when following directions from Customer, its employees or agents, and Customer agrees to indemnify UMR and hold it harmless from and against any and all claims arising from Customer's decision to make an exception to the SPD.
Transition to new Third Party Administrator (TPA). UMR will cooperate with Customers' transition to a new TPA upon termination of this Agreement and will provide cancellation reports to Customer upon request.	
Medicare Secondary Payer Reporting. UMR shall provide to applicable parties the applicable reports in a time and manner as required according to the Medicare Secondary Payer Mandatory Reporting Provisions (the Reporting Requirements) in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. UMR shall not be responsible for any noncompliance penalties in connection with the Reporting Requirements that are related to Customer's failure to provide the required data.	Customer agrees to provide to UMR in a timely manner and in an agreed upon format any and all data that UMR requires to comply with the Reporting Requirements.

EXHIBIT B – SERVICE FEES

This exhibit lists the fees Customer must pay UMR for UMR's services during the term of the Agreement. Unless otherwise noted, these fees apply for the period from January 1, 2019 through December 31, 20192021. Customer acknowledges that the amounts paid for administrative services are reasonable.

The fees below do not include state or federal surcharges, assessments, or similar taxes imposed by governmental entities or agencies on the Plan or UMR, including but not limited to those imposed pursuant to The Patient Protection and Affordable Care Act of 2010, as amended from time to time as these are the responsibility of the Plan.

Commented [MBarr22]: UMR: Refer to response in Section 5.

Service Code	ITEM	FEE and BASIS
	Medical Fees	
0001	Base Medical Fee	$21.55 PEPM in 2019 $22.09 PEPM in 2020 $23.64 PEPM in 2021
	ID Card Services	
0200	Mail ID Cards to Subscriber's Home	No Charge
	Banking Services	
0307	Custodial Banking Maintenance Charges	No Charge
0321	Pre-authorized Check Release	No Charge
	Reporting/Special Data Services	
0402	Development of Production Custom Reports/File Feeds	No Charge (sending enrollment applications pre-screeners to The House Next Door)
0417	Custom Ad-Hoc Reports – Request System	$100/hr. after 10 Hours Per Year
	Billing	
0804	Outside Vendor Payments	No Charge (NEFS/RITTERS Pharmacy)
	Claim Services	
~~0414~~	~~Claims Run-In~~	~~No Charge~~
0140	Claim Reprocessing	No Charge
	Other Fees	
0720	Referral Tracking	No Charge
1501	Assume Claims Fiduciary Responsibility	No Charge

Commented [MBarr23]: UMR: Not applicable

EXHIBIT C – BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("BAA") is incorporated into and made part of the Administrative Services Agreement ("Agreement") between UMR, Inc. on behalf of itself and its affiliates ("Business Associate") and West Volusia Hospital Authority ("Covered Entity") and is effective on July 1, 2018 (Effective Date).

The parties hereby agree as follows:

1. DEFINITIONS

1.1 Unless otherwise specified in this BAA, all capitalized terms used in this BAA not otherwise defined have the meanings established for purposes of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations as amended from time to time (collectively, "HIPAA").

1.2 "Privacy Rule" means the federal privacy regulations, as amended from time to time, issued pursuant to HIPAA and codified at 45 C.F.R. Parts 160 and 164 (Subparts A & E).

1.3 "Security Rule" means the federal security regulations, as amended from time to time, issued pursuant to HIPAA and codified at 45 C.F.R. Parts 160 and 164 (Subparts A & C).

1.4 "Services" means, to the extent and only to the extent they involve the receipt, creation, maintenance, transmission, use or disclosure of PHI, the services provided by Business Associate to Covered Entity as set forth in the Agreement, including those set forth in this BAA in Section 4, as amended by written agreement of the parties from time to time.

2. RESPONSIBILITIES OF BUSINESS ASSOCIATE

With regard to its use and/or disclosure of Protected Health Information (PHI), Business Associate agrees to:

2.1 not use and/or disclose PHI except as necessary to provide the Services, as permitted or required by this BAA and/or the Agreement, and in compliance with each applicable requirement of 45 C.F.R. 164.504(e), or as otherwise Required by Law; except that, to the extent Business Associate is to carry out Covered Entity's obligations under the Privacy Rule, Business Associate will comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of those obligations.

2.2 implement and use appropriate administrative, physical and technical safeguards and comply with applicable Security Rule requirements with respect to Electronic Protected Health Information, to prevent use or disclosure of PHI other than as provided for by this BAA and/or the Agreement.

2.3 without unreasonable delay, report to Covered Entity (i) any use or disclosure of PHI not provided for by this BAA and/or the Agreement, of which it becomes aware in accordance with 45 C.F.R. 164.504(e)(2)(ii)(C); and/or (ii) any Security Incident of which Business Associate becomes aware in accordance with 45 C.F.R. 164.314(a)(2)(i)(C).

2.4 with respect to any use or disclosure of Unsecured PHI not permitted by the Privacy Rule that is caused solely by Business Associate's failure to comply with one or more of its obligations under this BAA, Covered Entity hereby delegates to Business Associate the responsibility for determining when any such incident is a Breach. In the event of a Breach, Business Associate shall (i) provide Covered Entity with written notification, and (ii) provide all legally required notifications to Individuals, HHS and/or the media, on behalf of Covered Entity, in accordance with 45 C.F.R. 164 (Subpart D). Business Associate shall pay for the reasonable and actual costs associated with those notifications.

2.5 in accordance with 45 C.F.R. 164.502(e)(1)(ii) and 45 C.F.R. 164.308(b)(2), ensure that any subcontractors of Business Associate that create, receive, maintain or transmit PHI on behalf of Business Associate agree, in writing, to the same restrictions and conditions on the use and/or disclosure of PHI that apply to Business Associate with respect to that PHI.

2.6 make available its internal practices, books and records relating to the use and disclosure of PHI to the Secretary for purposes of determining Covered Entity's compliance with the Privacy Rule.

2.7 after receiving a written request from Covered Entity or an Individual, make available an accounting of disclosures of PHI about the Individual, in accordance with 45 C.F.R. 164.528.

2.8 after receiving a written request from Covered Entity or an Individual, provide access to PHI in a Designated Record Set about an Individual, in accordance with the requirements of 45 C.F.R. 164.524.

2.9 after receiving a written request from Covered Entity or an Individual, make PHI in a Designated Record Set about an Individual available for amendment and incorporate any amendments to the PHI, all in accordance with 45 C.F.R. 164.526.

3. RESPONSIBILITIES OF COVERED ENTITY

In addition to any other obligations set forth in the Agreement, including in this BAA, Covered Entity:

3.1 shall provide to Business Associate only the minimum PHI necessary to accomplish the Services.

3.2 shall notify Business Associate of any limitations in the notice of privacy practices of Covered Entity under 45 C.F.R. 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

3.3 shall notify Business Associate of any changes in, or revocation of, the permission by an Individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

3.4 shall notify Business Associate of any restriction on the use or disclosure of PHI that Covered Entity has agreed to or is required to abide by under 45 C.F.R. 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

3.5 In the event Covered Entity takes action as described in this Section, Business Associate shall decide which restrictions or limitations it will administer. In addition, if those limitations or revisions materially increase Business Associate's cost of providing Services under the Agreement, including this BAA, Covered Entity shall reimburse Business Associate for such increase in cost.

4. PERMITTED USES AND DISCLOSURES OF PHI

Unless otherwise limited in this BAA, in addition to any other uses and/or disclosures permitted or required by this BAA or the Agreement, Business Associate may:

4.1 make any and all uses and disclosures of PHI necessary to provide the Services to Covered Entity.

4.2 use and disclose PHI, if necessary, for proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, on the condition that the disclosures are Required by Law or any third party to which Business Associate discloses PHI for those purposes provides written assurances in advance that (i) the information will be held confidentially and used or further disclosed only for the purpose for which it was disclosed to the third party or as Required by Law, and (ii) the third party promptly will notify Business Associate of any instances of which it becomes aware in which the confidentiality of the information has been breached.

4.3 de-identify PHI received or created by Business Associate under this BAA in accordance with the Privacy Rule.

4.4 provide Data Aggregation services relating to the Health Care Operations of the Covered Entity in accordance with the Privacy Rule.

4.5 use and disclose PHI and data as permitted in 45 C.F.R 164.512 in accordance with the Privacy Rule.

4.6 use PHI to create, use and disclose a Limited Data Set in accordance with the Privacy Rule.

5. TERMINATION

5.1 Termination. If Covered Entity knows of a pattern of activity or practice of the Business Associate that constitutes a material breach or violation of this BAA then the Covered Entity shall provide written notice of the breach or violation to the Business Associate that specifies the nature of the breach or violation. The Business Associate must cure the breach or end the violation on or before thirty (30) days

after receipt of the written notice. In the absence of a cure reasonably satisfactory to the Covered Entity within the specified timeframe, or in the event the breach is reasonably incapable of cure, then the Covered Entity may terminate the Agreement and/or this BAA.

5.2 Effect of Termination or Expiration. After the expiration or termination for any reason of the Agreement and/or this BAA, Business Associate shall return or destroy all PHI, if feasible to do so, including all PHI in possession of Business Associate's subcontractors. In the event that Business Associate determines that return or destruction of the PHI is not feasible, Business Associate may retain the PHI and shall extend any and all protections, limitations and restrictions contained in this BAA to Business Associate's use and/or disclosure of any PHI retained after the expiration or termination of the Agreement and/or this BAA, and shall limit any further uses or disclosures solely to the purposes that make return or destruction of the PHI infeasible.

5.3 Cooperation. Each party shall cooperate in good faith in all respects with the other party in connection with any request by a federal or state governmental authority for additional information and documents or any governmental investigation, complaint, action or other inquiry.

6. MISCELLANEOUS

6.1 Construction of Terms. The terms of this BAA to the extent they are unclear shall be construed to allow for compliance by Covered Entity and Business Associate with HIPAA.

6.2 Survival. Sections 5.2, 5.3, 6.1, 6.2, and 6.3 shall survive the expiration or termination for any reason of the Agreement and/or of this BAA.

6.3 No Third Party Beneficiaries. Nothing in this BAA shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

EXHIBIT D – ADMINISTRATIVE SERVICES LIST

THIRD PARTY ADMINISTRATOR START UP

	Responsible Party		Included the Fee	Available But Extra charge	Not Available	Specify Cost if Extra
REQUIRED SERVICES	**WVHA**	**TPA**				
IMPLEMENTATION AND TRAINING			X			
Account Coordinator for implementation		X	X			
Implementation set-up		X	X			
System training • Initial • Follow-up		X	X			
Software support		X	X			
Custom programming		X		X		Depends on scope
Set up group and account data		X	X			
Build benefit plans		X	X			
Interpretation of benefit plan issues	X	X	X			

MEMBER SERVICES

	Responsible Party		Included in the fee	Available But Extra Charge	Not Available	Specify Cost if Extra
REQUIRED SERVICES	**WVHA**	**TPA**				
ELIGIBILITY/MEMBERSHIP						
Posting of electronic daily eligibility		X	X			
Verification of accuracy of eligibility	X	X	X			
Ongoing maintenance of eligibility	X	X	X			
Print ID cards		X	X			
Mailing ID cards and new member materials		X	X			
Mailing/Printing WVHA Member Handbook		X	X			
TPA Provider Web Portal search by patient name, date of birth or Social Security Number		X	X			

CLAIMS ADMINISTRATION

	Responsible Party		Included in fee	Available but Extra Charge	Not Available	Specify Cost if Extra
REQUIRED SERVICES	**WVHA**	**TPA**				
CLAIMS PROCESSING						
Accept paper and electronic claims		X	X			
Data entry and adjudication of claims		X	X			
Production of EOBs		X	X			
Mail EOB's and related correspondence		X	X			
Production of batched claims		X	X			
Production of checks		X	X			
Approval to release checks	X	X	X			
Mail checks		X	X			
Internet or electronic access for providers to check claim status		X	X			
Production of 1099s		X	X			
EDI and EFT Capability		X	X			
REPORTS						
Produce standard reports. See section III for detail (page 19)		X	X			
Report writer for client generated custom reports		X		X		$100/hour as per attached fees
TPA produced special/customized reports		X	X			
Data warehousing capability		X	X			

Provider Services

	Responsible Party		Included in the fee	Available But Extra Charge	Not Available	Specify Cost if Extra
REQUIRED SERVICES	**WVHA**	**TPA**				
PROVIDER SERVICES						
Provide provider add, change and termination information		X	X			
Enter/maintain provider data in system		X	X			
Enter/maintain provider fee schedules		X	X			
Toll-free line for providers		X	X			
Providers' phone inquiries – verify eligibility and benefits, claim status		X	X			
Automated phone system for call service management and reporting		X	X			
Monthly eligibility to providers via the web		X	X			
Electronic access to member data		X	X			
Preparation of provider directory and other material (including languages spoken)		X	X			
EDI or Internet provider access to member eligibility		X	X			
Internet or electronic access for providers to create and verify referrals and authorizations		X	X			
Provider satisfaction surveys re: TPA services	X	X		X		Depends on scope

REPORT LIST
INSTRUCTIONS

Commented [MBarr24]: UMR: Added chart from the RFP

"Yes" indicates that the report is included in the monthly fee charged.

In Patient Reports	Yes	Yes but extra charge-	No
	Yes		
Total bed days and admits in current and prior periods, YTD	Yes		
Bed days and admits per 1,000 members for current and prior periods	Yes		
Bed days and admits per hospital	Yes		
Bed days and admits by diagnosis	Yes		
Bed days and admits by PCP			No
Re-admissions within 30 days of prior discharge, by patient and diagnosis	Yes		
Outpatient Services Reports			
ED visits in current and prior periods, YTD	Yes		
ED visits by diagnosis	Yes		
ED visits by PCP	Yes		
ED visits by facility and PCP	Yes		
Outpatient surgery by diagnosis and facility	Yes		
Included preventive procedures by recommended category	Yes		
Included disease related procedures per disease	Yes		
Included disease related procedures per disease per PCP			No
Other procedures per PCP			No
Specialty visits per type of specialist	Yes		
Specialist visit per diagnosis	Yes		
Specialist visit by PCP			No
Financial and Claims Data Reports			
Turn-around-time reports/claims lag reports	Yes		
Percent and age of pended claims by reason code	Yes		

Duplicate claims reports by member and provider	**Yes**		
	Yes	**Yes but extra charge-specify**	**No**
Subrogation Services		**Yes – 30% recoveries**	
Outlier report – Claims billed, paid, denied for claim charge amounts exceeding $10,000.	**Yes**		
Claims total billed, paid, denied	**Yes**		
Per member per month medical costs by age and sex (groupings)	**Yes**		
High dollar payments by member name (top 25) and diagnosis	**Yes**		
High volume claims by CPT Code, total, and provider	**Yes**		

~~**Eligibility /Member Management and Member/Provider Services Reports**~~	~~**Yes**~~	~~**Yes but extra charge-specify**~~	~~**No**~~
~~Membership by unduplicated enrollment~~	~~Yes~~		
~~New members lists~~	~~Yes~~		
~~Terminated members lists~~	~~Yes~~		
~~Membership by demographics~~	~~Yes~~		
~~Membership by diagnostic category total and by PCP~~	~~Yes~~		
~~Monthly membership report based on information provided to TPA by separately contracted entity that qualifies the WVHA HealthCard Members~~	~~Yes~~		
~~Access to telephone services.~~ ~~- Average time to reach a non-recorded voice~~ ~~- Abandonment rates~~	~~Yes~~		
~~Number and type of complaints and appeals from members and providers~~	~~Yes~~		

Commented [MBarr25]: UMR:As of 1/1/2019, this is being performed by an outside vendor – The House Next Door

Administrative	**Yes**	**Yes but extra charge-specify**	**No**
Number of claims submitted for tracking only	**Yes**		

By provider	Yes		
Total	Yes		

Eileen Long

From: Jacobs, Shawn A <s.jacobs@umr.com>
Sent: Monday, January 07, 2019 5:34 PM
To: Eileen Long
Cc: Ron Cantlay; Al Powers; Denise Goodall; Shore, Michael J; Lupo, Donna E; Nicoletti, Dominick
Subject: WVHA December 2017 Duplicate Funding Details - Pomco Chase Bank account

Hi Eileen. I have discussed the notice below with Michael and after our research we discovered that the excess funds that remain in the old POMCO Chase account are based on a duplicate funding request. During that time of year we sent a special fund request (December 15th) for the Hospital facility claims that were previously denied prior to the end of WVHA's 2016/17 fiscal year due to them exhausting the budget. The following funding request was specific to those previously denied claims:

POMCO
EXPERIENCE EXCELLENCE

211 - West Volusia Hospital Auth - Fund Grouping

Start Date:
End Date:
Check Group: All

Grand Total Invoice $595,913.23

Fund Group	Amount
Family Health Source OB/GYN	$0.00
Family Health Source Daytona	$0.00
~~Family Health Source Deland~~ Fla Hosp Deland	$272,802.29
Family Health Source Deltona	$0.00
Family Health Source Pierson	$0.00
Florida Hospital Deland	$0.00
ACA Advance-FHD	$0.00
FHD Physician Services	$0.00
Florida Hospital Fish Memorial	$322,113.54

ACA Advance-FHFM	$0.00
FHFM Physician Services	$0.00
Laboratory Services	$0.00
Specialty Care Services	$997.40
Claims Check Run Total:	$595,913.23

TOTAL INVOICE:	$595,913.23

We believe that same amount was included again in error during the next WVHA regularly scheduled check funding request on December 22, 2017. As you may recall, we had very large gaps in staffing of the POMCO legacy teams after the acquisition by UMR and we believe this was missed while our oversite was limited.

That being said, with the 7/1/2018 migration to UMR we have full reconciliation details of the current UMR owned funding account and we can share all reconciliation details on a monthly basis going forward to help prevent this from happening again in the future. The UMR funding area can provide the reconciliation reports between the 10 and the 15th of the month following each reconciliation month.

We have found that the old POMCO Chase account did have 1 un-cashed provider check in the amount of $133.16 from a February 16, 2018 date of service that will be returned as well.

We sincerely apologize for the inconveniences that this brings and we are confident that the UMR protocols in place would prevent this from happening in the future while on the UMR platforms.

Let us know if you have any other questions as we prepare to send these funds (**595,913.23** = Duplicate funding of 596,046.39 + un-cashed check of$133.16) back to DRT on behalf of the WVHA health card program.

Regards,
S.A.J.

Shawn A. Jacobs
Strategic Account Executive | UMR
A UnitedHealthcare Company

UMR

shawn.jacobs@umr.com | Tel: **315.937.2790** | Fax: 315.703.4896

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From: Eileen Long [mailto:ELong@drtcpa.com]
Sent: Monday, January 07, 2019 10:52 AM
To: Shore, Michael J; Jacobs, Shawn A; Lupo, Donna E; Nicoletti, Dominick
Cc: Ron Cantlay; Al Powers; Denise Goodall
Subject: FW: Pomco bank account

Good morning all,

We need a response and explanation of the below refund ASAP as this has caused our independent audit to halt in its tracks.

Eileen O'Reilly Long

Dreggors, Rigsby & Teal, P.A.
Advisors for Life
Certified Public Accountants · Registered Investment Advisor

1006 N Woodland Blvd
DeLand FL 32720
386-734-9441 Office
386-738-5351 Fax
elong@drtcpa.com

From: Eileen Long
Sent: Wednesday, January 02, 2019 11:44 AM
To: 'Shore, Michael J' <Michael.Shore@umr.com>
Cc: Jacobs, Shawn A <s.jacobs@umr.com>; Ron Cantlay <RCantlay@drtcpa.com>; Al Powers <APowers@drtcpa.com>; Denise Goodall <DGoodall@drtcpa.com>
Subject: RE: Pomco bank account
Importance: High

Hello Michael,

I was out over the Christmas and News Years holiday and am only now seeing this email.

We need to know the fund grouping that this overage ties back to in order to accrue this appropriately. We need the detail in order to classify this back to the either specialty care, hospital claims, lab services, NEFHS, or pharmacy.

How did this happen? What safeguards can be put in place to avoid this going further? Also, doesn't POMCO/UMR reconcile this bank account? Further, we are formally requesting that UMR forward all monthly bank statements and bank account reconciliations to DRT, going back to the July 1, 2018 UMR migration and all future months. This is almost $600K that the WVHA did not earn any interest on those dollars. Our auditors have already completed their field work for our 2017-2018 fiscal year and this is going to halt that audit.

As for a bank account that you can wire the money into, please send it to the account of the West Volusia Hospital Authority, Intracoastal Bank, Routing #: 063116562 account #: 10060828.

This is a very alarming notification that we will be required to bring it before the WVHA Board of Commissioners.

Eileen O'Reilly Long

Dreggors, Rigsby & Teal, P.A.
Advisors for Life
Certified Public Accountants · Registered Investment Advisor

1006 N Woodland Blvd
DeLand FL 32720
386-734-9441 Office
386-738-5351 Fax
elong@drtcpa.com

From: Shore, Michael J [mailto:Michael.Shore@umr.com]
Sent: Thursday, December 27, 2018 1:39 PM
To: Eileen Long <ELong@drtcpa.com>
Cc: Jacobs, Shawn A <s.jacobs@umr.com>
Subject: Pomco bank account

Hello Eileen,

We are looking to close down the bank account that Pomco held at JP Morgan Chase for claim payments, as all activity has moved to the BMO Harris Bank account at UMR and there was only one remaining outstanding check. It appears there was a duplicate funding from Dec 2017 still in the Chase account, so there is 578,359.20 to be sent to West Volusia, and then we can close the account.

If possible, we would like to send the funds yet in 2018, but would need a bank account to transfer to by 1:00 EST tomorrow in order to do that.

West Volusia Hospital Authority
Schedule I - Healthcare Expenditures
Modified Cash Basis
Budget and Actual
For the 1 Month and 12 Months Ended September 30, 2018

	Annual Budget	Current Period Actual	Year To Date Actual	Budget Balance
Healthcare Expenditures				
Adventist Health Systems				
Florida Hospital DeLand	2,715,327	160,733	2,840,075	(124,748)
Florida Hospital Fish Memorial	2,715,327	227,129	2,572,962	142,365
Florida Hospital DeLand - Physicians	112,500	0	116,103	(3,603)
Florida Hospital Fish - Physicians	112,500	0	108,897	3,603
Northeast Florida Health Services				
NEFHS - Pharmacy	660,040	100,628	688,819	(28,779)
NEFHS - Obstetrics	30,000	3,252	35,476	(5,476)
NEFHS - Primary Care	918,322	218,837	927,416	(9,094)
Specialty Care				
Specialty Care Services	4,700,000	635,438	2,859,990	1,840,010
Laboratory Services	508,000	120,082	457,883	50,117
County Medicaid Reimbursement	2,250,000	195,966	2,258,770	(8,770)
Florida Dept of Health Dental Svcs	200,000	1,299	200,000	0
Good Samaritan				
Good Samaritan Health Clinic	25,000	4,204	24,706	294
Good Samaritan Dental Clinic	54,747	3,050	21,660	33,087
Global Healthcare System				
The House Next Door	120,000	29,406	104,932	15,068
The Neighborhood Center	70,000	9,425	70,000	0
Community Life Center Outreach Services	25,000	2,325	19,650	5,350
Rising Against All Odds	235,000	37,975	218,594	16,406
Community Legal Services	76,931	7,950	40,321	36,610
Hispanic Health Initiatives	75,000	3,550	75,000	0
Deltona Firefighters Foun Access to Hlth	75,000	0	661	74,339
Stewart Marchman - ACT				
SMA - ARNP Services at THND	7,000	88	2,129	4,871
SMA - Homeless Program	75,958	17,546	75,782	176
SMA - Residential Treatment	550,000	89,872	550,000	0
SMA - Baker Act - Match	325,000	58,092	245,629	79,371
Health Start Coalition of Flagler & Volusia				
HSCFV - Outreach	73,500	9,330	70,680	2,820
HSCFV - Fam Services	68,862	5,645	68,862	0
HCRA				
H C R A - In County	400,000	99,452	209,144	190,856
H C R A - Outside County	419,612	83,081	106,763	312,849
Other Healthcare Costs	315,047	0	0	315,047
Total Healthcare Expenditures	**17,913,673**	**2,124,355**	**14,970,904**	**2,942,769**

Eileen Long

From: Nicoletti, Dominick <dominick.nicoletti@umr.com>
Sent: Monday, December 17, 2018 11:46 AM
To: Eileen Long
Cc: Jacobs, Shawn A
Subject: West Volusia 2018 Medical Plan Document
Attachments: Plan 07-01-2018 01-01-2017 10-01-2018 00.pdf; Plan ltr 07-01-2018 01-01-2017 10-01-2018.pdf

Hello Eileen,

Attached is the 2018 Plan Document for you to review. If you approve please sign the acceptance page and return that to me. If you have any questions or would like something changed please let me know so we can address it.

Thank you!

Dominick J. Nicoletti
Field Account Manager | UMR
A UnitedHealthcare Company
2425 James Street | Syracuse, NY | 13206
Dominick.nicoletti@umr.com | Tel: 315.928.4667 | Fax: 315.433.5446

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DRG numbers: DRG0002151 and DRG0004808

UMR
A UnitedHealthcare Company

115 W Wausau Ave
Wausau WI 54401-2875

PO Box 8046
Wausau WI 54402-8046

WEST VOLUSIA HOSPITAL AUTHORITY

December 12, 2018

Plan Number: 7670-00-413413

Dear Valued Customer:

With this letter, we are sending your modified Health summary plan description (SPD). This SPD, referred to as the plan document, is the governing plan document that will be the basis for the administration of your Health Plan.

Also enclosed is the Acceptance Page. A signed Acceptance Page formally approves that the plan document governs and is the basis for the administration of the plan. Please sign, retain a copy for your records, and return one copy to your UMR strategic account executive as soon as possible. **Note, however, that since the corresponding system changes have been implemented, this document is considered final, regardless of whether or not a signature is received.**

UMR relies on the plan document to administer benefits. **If you want UMR to print your SPD or to post it to the UMR member portal, please understand that we cannot do so until we receive a signed Acceptance Page.** Please also understand that it is important for you to be sure your formally approved plan document matches the information contained in any summary plan material distributed to your employees, since this document will contain the terms of plan coverage.

Any applicable stop-loss policies typically rely solely on the last formally approved plan document when determining coverage. If the plan document distributed to your employees differs from the way your plan document describes plan administration, the result can be a lapse or gap in stop-loss coverage. **Important:** To prevent a potential lapse or gap in stop-loss coverage, or delays with your stop-loss policy or claims, be sure to return the signed Acceptance Page to your UMR strategic account executive in a timely fashion. If applicable, submit a copy of the Acceptance Page along with a copy of your current plan document to your stop loss carrier, which will constitute required notice. Please keep a copy for your records. Stop loss policies do not provide coverage for plan terms or conditions unknown to the policy administrators. Stop loss carriers require notice of all plan terms and conditions.

If you have any questions, please contact your UMR strategic account executive.

Thank you for your business.

Daryl Aguirre
Case Installations
Enclosure

UMR
A UnitedHealthcare Company

SUMMARY OF MODIFICATIONS

As requested, effective January 1, 2017, the following change(s) were made to your Health Plan document. The change(s) are shaded in the plan document, with the exception of deleted wording:

- Any reference to services that has a co-payment amount reflected a note that states one Co-pay applies per provider per day for any Physician charge.

SUMMARY OF MODIFICATIONS

As requested, effective October 1, 2018, the following change(s) were made to your Health Plan document. The change(s) are shaded in the plan document, with the exception of deleted wording:

- Medical Schedule of Benefits, Benefit Plan(s) 001:
  - Primary Care Physician and Specialist Co-payment have been changed all throughout the Plan Document.
  - Under Emergency Services / Treatment, Emergency Room co-pay per visit has been changed.
  - Manipulations co-pay per visit has been changed.
  - Under Therapy Services, occupational / physical / speech office therapy co-pay per visit has been changed.
  - under Pharmacy Services, copay per prescription has been changed

ACCEPTANCE PAGE

Health Plan
7670-00-413413

WEST VOLUSIA HOSPITAL AUTHORITY acknowledges that we have reviewed the plan document for the plan period effective January 1, 2017 and October 1, 2018, and agree that the provisions contained in the plan document will be the basis for the administration of our Health Plan. The Plan Sponsor further represents that the plan document accurately reflects the intent of the Plan Sponsor and agrees that UMR may rely on such document in the administration of the Plan.

Accepted by the Plan Sponsor on _____
Date

_____
Authorized Signature and Title
WEST VOLUSIA HOSPITAL AUTHORITY

WEST VOLUSIA HOSPITAL AUTHORITY
DELAND FL

Health Benefit Summary Plan Description
7670-00-413413

BENEFITS ADMINISTERED BY

UMR℠

A UnitedHealthcare Company

Table of Contents

WEST VOLUSIA HOSPITAL AUTHORITY

GROUP HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan as well as with information on a Covered Person's rights and obligations under the WEST VOLUSIA HOSPITAL AUTHORITY Group Health Benefit Plan (the "Plan"). You are a valued ~~Employee~~ of WEST VOLUSIA HOSPITAL AUTHORITY, and ~~Your employer~~ is pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions or if You have difficulty translating this document.

WEST VOLUSIA HOSPITAL AUTHORITY is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrator for this Plan is UMR, Inc. (hereinafter "UMR") for medical claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, since they are solely claims-paying agents for the Plan Administrator.

The ~~employer~~ assumes the sole responsibility for funding the Plan benefits out of general assets; however, ~~Employees~~ help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the ~~employer~~ and there is no separate fund that is used to pay promised benefits.

Some of the terms used in this document begin with capital letters, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

Each individual covered under this Plan will be receiving an identification card that he or she may present to providers whenever he or she receives services. On the back of this card are phone numbers to call in case of questions or problems.

This document contains information on the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan document. Therefore it will be referred to as both the SPD and the Plan document.

This document became effective on July 1, 2018.

PLAN INFORMATION

Plan Name	WEST VOLUSIA HOSPITAL AUTHORITY GROUP HEALTH BENEFIT PLAN
Name And Address Of ~~Employer~~ WVHA	WEST VOLUSIA HOSPITAL AUTHORITY 1006 N WOODLAND BLVD DELAND FL 32720
Name, Address, And Phone Number Of Plan Administrator	WEST VOLUSIA HOSPITAL AUTHORITY 1006 N WOODLAND BLVD DELAND FL 32720 386-626-4870
Named Fiduciary	WEST VOLUSIA HOSPITAL AUTHORITY
Claims Appeal Fiduciary For Medical Claims	UMR
Employer Identification Number Assigned By The IRS	59-6045131
Type Of Benefit Plan Provided	Self-funded Health and Welfare Plan providing group health benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	WEST VOLUSIA HOSPITAL AUTHORITY 1006 N WOODLAND BLVD DELAND FL 32720
Benefit Plan Year only 6 months of eligibility	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
Plan's Fiscal Year	October 1 through September 30
Compliance	It is intended that this Plan comply with all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator will perform its duties as the Plan Administrator and in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in their sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 001

Effective: 01-01-2017, 10-01-2018

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Benefits listed in this Schedule of Benefits are subject to all provisions of the Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan	100%	
Cardiac Pulmonary Rehabilitation: • Maximum Visits Per Lifetime • Paid By Plan $10 copay	36 Visits 100%	No Benefit
Cardiac Rehabilitation Phase 1 & 2: • Maximum Visits Per Occurrence • Paid By Plan $10 copay	3 Visits Per Week To A Maximum Of 18 Consecutive Weeks 100%	No Benefit
Chiropractic Care: • Maximum Visits Per Calendar Year • Paid By Plan $10 copay	30 Visits 100%	No Benefit
Diabetic Supplies: • Co-pay Per Visit - Primary Care Physician • Co-pay Per Visit - Specialist • Paid By Plan ***Note: One Co-pay Applies Per Provider Per Day For Any Physician Charge.***	$5 $10 100%	No Benefit
Emergency Services / Treatment: **Urgent Care Only:** • Paid By Plan **Urgent Care Physician Only:** • Co-pay Per Visit - Primary Care Physician • Co-pay Per Visit - Specialist • Paid By Plan ***Note: One Co-pay Applies Per Provider Per Day For Any Physician Charge.***	100% $5 $10 100%	No Benefit

Effective: 01-01-2017, 10-01-2018	IN-NETWORK	OUT-OF-NETWORK
Emergency Room Only: • Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours) • Paid By Plan **Emergency Physicians Only:** • Paid By Plan	$25 100% 100%	
Hospital Services: **Pre-Admission Testing:** • Paid By Plan **Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:** • Paid By Plan **Outpatient Services / Outpatient Physician Charges:** • Paid By Plan **Outpatient Advanced Imaging Charges:** • Co-pay Per Visit • Paid By Plan **Outpatient Lab And X-Ray Charges:** • Co-pay Per Visit • Paid By Plan **Outpatient Surgery / Surgeon Charges:** • Co-pay Per Visit • Paid By Plan ***Note: One Co-pay Applies Per Provider Per Day For Any Physician Charge.***	 100% 100% 100% $10 100% $10 100% $10 100%	No Benefit
Insulin: • Co-pay Per Visit - Primary Care Physician • Co-pay Per Visit - Specialist • Paid By Plan ***Note: One Co-pay Applies Per Provider Per Day For Any Physician Charge.***	$5 $10 100%	No Benefit
Manipulations: • Co-pay Per Visit • Maximum Visits Per Calendar Year • Paid By Plan ***Note: One Co-pay Applies Per Provider Per Day For Any Physician Charge.*** **Visit Maximums Are Applied Based On Provider Designation And Procedure Code.** **If A Provider Bills For A Manipulation And A Therapy On The Same Claim, Only One Visit Will Be Applied To The Manipulation Maximum Based On The Provider's Designation.**	$10 24 Visits 100%	No Benefit

Effective: 01-01-2017, 10-01-2018	IN-NETWORK	OUT-OF-NETWORK
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits:		No Benefit
Inpatient Services / Physician Charges:		
• Paid By Plan	100%	
Residential Treatment:		
• Paid By Plan	100%	
Outpatient Or Partial Hospitalization Services Only:		
• Paid By Plan	100%	
Outpatient Or Partial Hospitalization Physician Only:		
• Maximum Visits Per Day	1 Visit	
• Paid By Plan	100%	
Office Visit:		
• Co-pay Per Visit - Primary Care Physician	$5	
• Co-pay Per Visit - Specialist	$10	
• Paid By Plan	100%	
Note: One Co-pay Applies Per Provider Per Day For Any Physician Charge.		
Note: Medical Necessity Of Outpatient Therapy Services Will Be Reviewed After 25 Visits For Speech Therapy And Occupational Therapy.		
Physician Office Services:		No Benefit
• Co-pay Per Visit - Primary Care Physician	$5	
• Co-pay Per Visit - Specialist	$10	
• Paid By Plan	100%	
Note: One Co-pay Applies Per Provider Per Day For Any Physician Charge.		
Note: Co-pay Waived For OB/GYN. Referral Required For Specialist Coverage.		
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		No Benefit
• Co-pay Per Exam - Primary Care Physician	$5	
• Co-pay Per Exam - Specialist	$10	
Note: One Co-pay Applies Per Provider Per Day For Any Physician Charge.		
Preventive / Routine Physical Exams At Appropriate Ages:		
• Paid By Plan	100%	
Immunizations:		
• Paid By Plan	100%	
Note: Foreign Travel Immunizations Will Not Be Covered.		

Effective: 01-01-2017, 10-01-2018	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages: • Paid By Plan	100%	
Preventive / Routine Mammograms And Breast Exams: • Maximum Exams Per Calendar Year Including 3D Mammograms For Preventive Screenings • Paid By Plan	1 Exam 100%	
3D Mammograms For Preventive Screenings: Included In Preventive / Routine Mammograms And Breast Exams Maximum • Paid By Plan	100%	
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit: • Paid By Plan	100%	
Preventive / Routine Pelvic Exams And Pap Tests: • Maximum Exams Per Calendar Year • Paid By Plan	1 Exam 100%	
Preventive / Routine PSA Test And Prostate Exams: From Age 50 • Maximum Exams Per Calendar Year • Paid By Plan ***Note: Allowed From Age 40 With Family History.***	1 Exam 100%	
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons: From Age 50 • Paid By Plan	100%	
Therapy Services: **Occupational / Physical / Speech Outpatient Hospital Therapy:** • Paid By Plan	100%	No Benefit
Occupational / Physical / Speech Office Therapy: • Co-pay Per Visit • Paid By Plan ***Note: One Co-pay Applies Per Provider Per Day For Any Physician Charge.*** ***Note: Medical Necessity Will Be Reviewed After 25 Visits For Occupational Therapy And Physical Therapy.***	$10 100%	
All Other Covered Expenses: • Paid By Plan	100%	No Benefit

wouldn't each of these qualify as specialty care thus incurring a $10.00 copay?

N/A

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leaves of absence or furloughs. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following a military leave of absence may not be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- A period beginning on the day that the service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed service, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election of, payment for, and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Continuation of Coverage section, to the extent the COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENTLY

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed eligible for the COBRA extension only because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

The word **"Network"** means an organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Plan Participation amounts, or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing to which Network a provider belongs will help a Covered Person determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons should receive services from In-Network providers. However, this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

not a true statement

To find out to which Network a provider belongs, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

  WVHA – West Volusia Hospital Authority

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits.

Provider Directory Information

Each covered ~~Employee~~ member, COBRA participant, and Child or guardian of a Child who is considered an alternate recipient under a Qualified Medical Child Support Order will automatically be given or electronically provided a separate document, at no cost, that lists the participating Network providers for this Plan. The ~~Employee~~ member should share this document with other covered individuals in his or her household. If a covered spouse or Dependent wants a separate provider list, he or she may make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

ACCESS TO CARE

The Referral Process

The Primary Care Physician (PCP) will direct and coordinate all of the Reimbursable Medical Services. Whenever a Medically Necessary Reimbursable Medical Service is needed and cannot be provided by the PCP, the PCP will suggest and choose the appropriate contracted provider, such as a specialist or ancillary provider. Initial referrals to contracted providers must be arranged and approved by the PCP.

Specialists who have active referral from the PCP can submit their own specialty care referrals within the network as needed. Specialist direct referrals will have a maximum 90-day window based on the initial active referral initiated by the PCP. After submitting the referral directly through the referral tool, specialty care providers are required to also fax a copy of their referral request directly to the PCP center where the WVHA member started their care.

Effective: 01-01-2017, 10-01-2018

Out of Network Specialty Providers

If a member makes a visit to a provider that is not contracted by the West Volusia Hospital Authority Program (WVHA), any resulting medical bills will be paid by the member.

Non-Emergency Hospital Care

If a member needs to go to the Hospital, the following steps must be followed:

- The only Hospitals approved by the WVHA Program are Fish Memorial and Florida Hospital DeLand.
- Hospital services, including patient (overnight stay) or outpatient (one day only), need to be approved by the PCP. WVHA Program will approve claims payment for reimbursable services at participating Hospitals only except when member is treated in the Emergency Room at a participating Hospital.
- The member must show their Plan Identification Card (ID) during admittance to the Hospital.

Billing for Services

Providers and Hospitals will submit bills directly to WVHA Program Billing Agency. The member is only responsible for the Co-pay.

Payment of Co-pays

When a Co-pay is required, it will be paid directly to the provider.

SERVICE TYPE	CO-PAY
Primary Care Physician	$5 copayment
Specialist Visits	$10 copayment
Prescription Drug	$3 copayment
Emergency Room	$25 copayment
Hospital ***Note: One Co-pay Applies Per Provider Per Day For Any Physician Charge.***	$0 copayment

Reimbursable Services

The member may receive reimbursable medical services which are performed, prescribed, or referred by their Primary Care Physician, with the exception of any exclusion listed below. The WVHA Program may include, but not be limited to, preventive health services, community nursing services, ambulatory care, outpatient services, Hospital services, trauma health services, and rehabilitative services, as feasible.

SERVICE TYPE	BENEFIT
Preventive Health Care	Includes periodic evaluations and immunizations for pediatrics and adults. Services will be provided by the PCP.
Specialist Visits	Reimbursed when approved by the PCP and with participating providers.

Ambulatory Outpatient Services	Reimbursed when approved by the PCP and performed in a participating Hospital (Fish Memorial and Florida Hospital DeLand).
Hospital Admissions	Reimbursed at participating Hospitals (Fish Memorial and Florida Hospital DeLand).
Laboratory Services	Reimbursed only at Quest Diagnostic Laboratory.
Pharmacy Benefits	Medication listed in the Preferred Drug List only. Prescriptions must be filled at ~~Ritter~~'s Pharmacy. NEFHS As of 10/1/2018
Dental Services	Reimbursed when approved by the PCP and with participating dentists.
Mental Health	Reimbursed when approved by the PCP and with participaitng providers.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent International Classification of Diseases (ICD) or Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

1. **3D Mammograms,** for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care benefits.

2. **Abortions (Elective).**

3. **Allergy Treatment,** including injections and sublingual drops, testing and serum.

4. **Anesthetics and Their Administration.**

5. **Cardiac Pulmonary Rehabilitation** when Medically Necessary when needed as a result of an Illness or Injury.

6. **Cardiac Rehabilitation** programs are covered when Medically Necessary, if referred by a Physician, for patients who have certain cardiac conditions.

   Covered services include:

   - Phase I cardiac rehabilitation, while the Covered Person is an Inpatient.
   - Phase II cardiac rehabilitation, while the Covered Person is in a Physician-supervised Outpatient, monitored, low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure, and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

7. **Cataract or Aphakia Surgery** as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal lenses are not allowable.

8. **Chemotherapy**. Limited to anticancer treatments that are not in an investigational or experimental stage to include antineoplastic agents (such as anticancer drugs) or agents used to destroy microorganisms (such as antibiotic drugs). Excludes oral chemotherapy, subcutaneous injections and intramuscular injections that are not in an investigational or experimental stage.

9. **Circumcision** and related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

10. **Cleft Palate and Cleft Lip,** benefits will be provided for initial and staged reconstruction of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

11. **Contraceptives and Counseling:** All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling. This Plan provides benefits for Prescription contraceptives, regardless of purpose. Prescription contraceptives that require that a Physician administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this SPD.

12. **Cornea Transplants** are payable at the percentage listed under "All Other Covered Expenses" on the Schedule of Benefits.

13. **Dental Services** include:

    - Inpatient or Outpatient Hospital charges, including professional services for X-rays, laboratory services, and anesthesia while in the Hospital, if Medically Necessary.
    - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

14. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs, diabetic shoes and nutritional counseling.

15. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. Coverage also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same as for any other Illness.

16. **Emergency Room Hospital and Physician Services,** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

17. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed.
    - Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
    - Physician office visit for diagnosis of bunions. The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed.

18. **Hearing Services** include exams, tests, services, and supplies to diagnose and treat a medical condition.

19. **Hospital Services (Including Inpatient Services, Surgical Centers, and Inpatient Birthing Centers).** The following services are covered:

    - Semi-private room and board. For network charges, this rate is based on network re-pricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate, subject to Usual and Customary charges, or the Negotiated Rate, whichever is applicable.
    - Intensive care unit room and board.
    - Miscellaneous and Ancillary Services.
    - Blood, blood plasma, and plasma expanders, when not available without charge.

Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

20. **Hospital Services (Outpatient).**

    Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

21. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

22. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition of, alleviates the symptoms of, slows the harm to, or maintains the current health status of the Covered Person.

    Infertility Treatment does not include genetic testing. (See General Exclusions for details).

23. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits. Charges by a pathologist for interpretation of computer-generated automated laboratory test reports are not covered by the Plan.

24. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

25. **Maternity Benefits** for the ~~Employee~~ Member or spouse include:

    - Hospital or Birthing Center room and board.
    - Vaginal delivery or Cesarean section.
    - Non-routine prenatal care.
    - Postnatal care.
    - Diagnostic testing.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Outpatient Birthing Centers.
    - Midwives.

26. **Mental Health Treatment.** (Refer to the Mental Health Benefits section of this SPD.)

27. **Nursery and Newborn Expenses, Including Circumcision,** are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

28. **Nutritional Counseling** if Medically Necessary.

29. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** that are prescribed by a Physician and administered through a tube, provided they are the sole source of nutrition or are part of a chemotherapy regimen. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings), provided the feedings are prescribed by a Physician and are the sole source of nutrition or are part of a chemotherapy regimen.

30. **Occupational Therapy.** (See Therapy Services below.)

31. **Oral Surgery** includes:

- Excision of partially or completely impacted teeth.
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological examinations.
- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
- Reduction of fractures and dislocations of the jaw.
- External incision and drainage of cellulitis.
- Incision of accessory sinuses, salivary glands, or ducts.
- Excision of exostosis of jaws and hard palate.

32. **Orthotic Appliances, Devices, and Casts,** covered only for joint immobilization.

33. **Oxygen and its Administration.**

34. **Pharmacological Medical Case Management** (medication management and lab charges).

35. **Physical Therapy.** (See Therapy Services below.)

36. **Physician Services** for covered benefits.

37. **Pre-Admission Testing** if necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

38. **Prescription Medications** that are administered or dispensed as take-home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility, or Skilled Nursing Facility) and that require a Physician's Prescription. Coverage does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

39. **Preventive / Routine Care** as listed under the Schedule of Benefits.

The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility, or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes, and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Well-women Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-women visit should, where appropriate, include the following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:

  - Screening for gestational diabetes;
  - Human papillomavirus (HPV) DNA testing;
  - Counseling for sexually transmitted infections;

- Counseling and screening for human immune-deficiency virus;
- Screening and counseling for interpersonal and domestic violence; and
- Breast cancer genetic test counseling (BRCA) for women at high risk.

Please visit the following links for additional information:

https://www.healthcare.gov/preventive-care-benefits/
https://www.healthcare.gov/preventive-care-children/
https://www.healthcare.gov/preventive-care-women/

40. **Radiation Therapy and Chemotherapy** when Medically Necessary.

41. **Radiology and Interpretation Charges.**

42. **Reconstructive Surgery** includes:

- Surgery following a mastectomy under the Women's Health and Cancer Rights Act (WHCRA). Under the WHCRA, the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments that include all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
- Surgery to restore a bodily function that has been impaired by a congenital Illness or anomaly, or by an Accident, or from an infection or other disease of the involved part.

43. **Respiratory / Inhalation Therapy.** (See Therapy Services below.)

44. **Second Surgical Opinion** if given by a board-certified Specialist in the medical field related to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

45. **Sleep Disorders** if Medically Necessary.

46. **Sleep Studies.**

47. **Speech Therapy.** (See Therapy Services below.)

48. **Sterilizations.**

49. **Substance Use Disorder Services** except participation in programs of a social, recreational or companionship nature. (Refer to the Substance Use Disorder and Chemical Dependency Benefits section of this SPD.)

50. **Surgery and Assistant Surgeon Services.**

- If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's allowance.
- If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the allowance for the primary procedure; and a percentage of the allowance for the subsequent procedure(s). If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the allowance for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the allowable amount for that procedure.

51. **Therapy Services:** Therapy must be ordered by a Physician related to a medical condition and provided as part of the Covered Person's treatment plan. Services include:

- **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable except recreational programs, maintenance therapy, or supplies used in occupational therapy.
- **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable.
- **Respiratory / Inhalation therapy** by a Qualified respiratory therapist (RT) or other Qualified Provider, if applicable except custodial or maintenance care.
- **Speech therapy** by a Qualified speech therapist (ST), or other Qualified Provider, if applicable, including therapy for stuttering due to a neurological disorder.

52. **Tobacco Addiction:** Preventive / Routine Care as required by applicable law and diagnoses, services, treatment, and supplies related to addiction to or dependency on nicotine.

53. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD. Limited to facilities affiliated to the Hospitals or with Urgent Care facilities that are bound to the same patient care guidelines as the hospitals.

54. **Walk-In Retail Health Clinics:** Charges associated with medical services provided at Walk-In Retail Health Clinics.

HOME HEALTH CARE BENEFITS

N/A

Home Health Care services are provided for patients when Medically Necessary, as determined by the Utilization Review Organization.

Prior authorization may be required before receiving services. Please refer to the Care Management section of this SPD for more details. Covered services may include:

- Home visits instead of visits to the provider's office that do not exceed the maximum allowable under this Plan.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed 4 hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a Qualified dietician or other Qualified Provider, if applicable.
- Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a Qualified therapist or other Qualified Provider, if applicable.
- Medical supplies, drugs, laboratory services, or medication prescribed by a Physician.

A Home Health Care Visit is defined as a visit by a nurse providing intermittent nurse services (each visit includes up to a 4-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, or other Qualified Provider, if applicable.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners, and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports, or transportation.
- Expenses for the normal necessities of living, such as food, clothing, and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g. therapeutic boarding schools, half-way houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered, subject to all of the following:

- The Covered Person must receive the services in person at a therapeutic medical facility; and
- The services must be provided by a Qualified Provider. If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- A medication evaluation by a psychiatrist may be required before a Physician can prescribe medication for a psychiatric condition. Periodic evaluations may be requested by the Plan.
- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.
- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.
- Services provided for conflict between the Covered Person and society that is solely related to criminal activity.
- Services for biofeedback.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay for the following Covered Expenses for a Covered Person, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, the Usual and Customary amount, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of substance use disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance related disorders. (Coverage does not include services provided in a community based residential facility, or group home.)

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered, subject to all of the following:

- The Covered Person must receive the services in person at a therapeutic medical facility; and
- The services must be provided by a Qualified Provider. If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located, or a therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry. The attending Physician, psychiatrist, or counselor must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of substance use disorder and chemical dependency disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for the change. Such records must include the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

SUBSTANCE USE DISORDER EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for the following:

- Treatment or care considered inappropriate or substandard as determined by the Plan.
- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not however, apply to Prescription benefits.** The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts, such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies (including no-fault policies). See the order of benefit determination rules (below).
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid. See below.

However, this Plan does not coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply:

- The plan that has no coordination of benefits provision is considered primary.

- If an individual is covered under one plan as a dependent and another plan as an employee, member, or subscriber, the plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) is considered primary. This does not apply to COBRA participants. See continuation coverage below. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any employee plan beneficiary to be eligible for primary benefits from his or her employer's benefit plan.

- The plan that covers a person as a dependent is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent. See continuation coverage below. Also see the section on Medicare, below, for exceptions.

- If an individual is covered under a spouse's plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.

- If one or more plans cover the same person as a dependent child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

    If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated, (whether or not they have ever been married), the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or dependent of an active employee), and is also covered under another plan as a retired or laid-off employee (or dependent of a retired or laid-off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See the exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that has covered the person as an employee, member, subscriber, or retiree the longest is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses may be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including through Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:
  - You continue to be actively ~~employed by~~ the ~~employer~~ and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
  - You continue to be actively ~~employed by~~ the ~~employer~~, Your covered spouse becomes eligible for and enrolls in Medicare, and Your spouse is also covered under a retiree plan through his or her former employer. In this case, this Plan pays first for You and Your covered spouse, Medicare pays second, and the retiree plan pays last.
  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period may also include COBRA continuation coverage or another source of coverage. At the end of the 30-month period, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
  - You are no longer actively employed by an employer; and
  - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also has COBRA continuation coverage through the Plan; or
  - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first; however, COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or
  - You or Your covered spouse has retiree coverage plus Medicare coverage; or
  - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying as the Primary Plan, the person may continue to receive Medicare benefits on a primary basis).
- Medicare is the secondary payer when no-fault insurance, Workers' Compensation, or liability insurance is available as the primary payer.

TRICARE

If an eligible ~~Employee~~ member is on active military duty, TRICARE is the only coverage available to that Employee. Benefits are not coordinated with the Employee's health insurance plan.

In all instances where an eligible ~~Employee~~ member is also a TRICARE beneficiary, ~~TRICARE will pay secondary to this employer-provided Plan.~~ the WVHA will not pay any claims

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

GENERAL EXCLUSIONS

Exclusions, including complications from excluded items, are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for expenses Incurred for the following, unless otherwise stated below. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of the Injury when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **3D Mammograms,** unless covered elsewhere in this SPD.

2. **Acts of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

3. **Acupuncture Treatment.**

4. **Alternative / Complementary Treatment** including treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.

5. **Ambulance.**

6. **Appointment Missed:** An appointment the Covered Person did not attend.

7. **Aquatic Therapy.**

8. **Assistance With Activities of Daily Living.**

9. **Assistant Surgeon, Co-Surgeons, or Surgical Team Services**, unless determined to be Medically Necessary by the Plan.

10. **Autism Services:** for treatment of autism after diagnosis.

11. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins or after coverage ends under this Plan.

12. **Bereavement Counseling.**

13. **Biofeedback Services.**

14. **Blood:** Blood donor expenses.

15. **Blood Pressure Cuffs / Monitors.**

16. **Breast Pumps,** unless covered elsewhere in this SPD.

17. **Breast Reductions.**

18. **Cardiac Rehabilitation** beyond Phase II, including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

19. **Claims** received later than 60 days from the date of service while Hospitals have 90 days.

20. **Contraceptive Products and Counseling,** unless covered elsewhere in this SPD.

21. **Cost of Services** performed by another institutional facility while hospitalized in a facility.

22. **Cosmetic Treatment, Cosmetic Surgery,** or any portion thereof including chelation therapy when used for cosmetic reason, unless the procedure is otherwise listed as a covered benefit.

    Cosmetic, medical, surgical, and non-surgical treatments and procedures provided primarily for cosmetic purposes include but are not limited to:

    - Surgery to the upper and lower eyelid;
    - Penile implant;
    - Augmentation mammoplasty;
    - Reduction mammoplasty for male or female or other cosmetic procedure to the breast;
    - Removal of breast implants except in post mastectomy surgery;
    - Full or partial face lift;
    - Dermabrasion or chemical exfoliation;
    - Scar revision;
    - Otoplasty;
    - Surgical lift, stretch, or reduction of the abdomen, buttock, thighs or upper arm;
    - Silicone injections to any part of the body;
    - Rhinoplasty;
    - Hair transplant; and
    - Tattoo removal.

23. **Court-Ordered:** Any treatment or therapy that is court-ordered, hospital treatment while under arrest by, in custody of, being guarded by a law enforcement officer, or under house arrest or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving-while-intoxicated conviction or other classes ordered by the court.

24. **Custodial, Domiciliary, Convalescent or Rest Care** in a Skilled Nursing Facility as defined in the Glossary of Terms of this SPD.

25. **Custom-Molded Shoe Inserts,** including the exam for required Prescription and fitting.

26. **Dental Services:**

    - The care and treatment of teeth or gums, alveolar processes, dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges, including professional charges for X-rays, labs, and anesthesia; to charges for treatment of Injuries to natural teeth, including replacement of such teeth with dentures; treatment of a cleft palate; or to charges for the setting of a jaw that was fractured or dislocated in an Accident.
    - Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
    - Dental implants, including preparation for implants.

27. **Developmental Delays:** Occupational, physical, and speech therapy services related to Developmental Delays, intellectual disability, or behavioral therapy. These services are not Medically Necessary and are not considered by the Plan to be medical treatment. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

28. **Duplicate Services and Charges or Inappropriate Billing,** including the preparation of medical reports and itemized bills.

29. **Education:** Charges for education, special education, job training, music therapy, and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

30. **Environmental Devices:** Environmental items such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, and vacuum devices.

31. **Examinations:** Examinations for employment, insurance, licensing, or litigation purposes.

32. **Excess Charges:** Charges or the portion thereof that are in excess of the Usual and Customary charge, the Negotiated Rate, or the fee schedule.

33. **Experimental, Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment. Plan also excludes any service provided or received without having been prescribed, directed or authorized by the health care district, except in cases of emergency.

34. **Extended Care:** Any Extended Care Facility Services that exceed the appropriate level of skill required for treatment as determined by the Plan.

35. **External Counter Pulsation.**

36. **Family Planning:** Consultations for family planning.

37. **Financial Counseling.**

38. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment, and health club memberships, or other utilization of services, supplies, equipment, or facilities in connection with weight control or bodybuilding.

39. **Foot Care (Podiatry):** Routine foot care.

40. **Foreign Coverage for Medical Care Expenses, Including Preventive Care or Elective Treatment.**

41. **Gender Transition:** Treatment, drugs, medicines, services, and supplies for, or leading to, gender transition surgery.

42. **Genetic Counseling,** unless covered elsewhere in this SPD.

43. **Genetic Testing,** unless covered elsewhere in this SPD.

44. **Growth Hormones.**

45. **Health or Beauty Aids, or Hair Analysis.**

46. **Hearing Services:**

    - Purchase or fitting of hearing aids unless covered elsewhere in this SPD.
    - Implantable hearing devices, unless covered elsewhere in this SPD.

47. **Home Births** and associated costs.

48. **Home Health Care.**

49. **Home Modifications:** Modifications to Your home or property, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, or ramps.

50. **Hospice Care.**

51. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.

52. **Infertility Treatment:**

- Fertility tests.
- Surgical reversal of a sterilized state that was a result of a previous surgery.
- Direct attempts to cause pregnancy by any means, including, but not limited to, hormone therapy or drugs including human chorionic gonadotropin (HCG)..
- Artificial insemination; in vitro fertilization; gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT).
- Embryo transplantation.
- Freezing or storage of embryo, eggs, or semen.
- Genetic testing.

This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition of, slow the harm to, alleviate the symptoms of, or maintain the current health status of the Covered Person.

53. **Intraocular Lenses Other Than Conventional Intraocular Cataract Lenses.**

54. **Lamaze Classes** or other childbirth classes.

55. **Learning Disability:** Non-medical treatment, including, but not limited to, special education, remedial reading, school system testing, and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

56. **Liposuction,** unless covered elsewhere in this SPD.

57. **Long-term Care, Chronic Care, or Nursing Home Care Services.**

58. **Maintenance Therapy** if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve a condition, or if clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

59. **Mammoplasty or Breast Augmentation,** unless covered elsewhere in this SPD.

60. **Marriage Counseling.**

61. **Massage Therapy.**

62. **Maternity Other Than Routine Prenatal Medical Care Expenses** for Covered Persons other than the Employee or spouse.

63. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

64. **Military:** Treatment for military service connected disabilities for which the Veterans Administration and military Hospital system provides care to which the member is legally entitled and when such facilities are reasonably available within the service area.

65. **Morbid Obesity Treatment:**

- Gastric bypass.
- Gastric banding and gastric stapling.
- Other surgical experimental or investigational procedures for the treatment of obesity, weight loss and/or weight management.

66. **Nocturnal Enuresis Alarm** (Bed wetting).

67. **Non-Custom-Molded Shoe Inserts.**

68. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.

69. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities, or equipment that reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy above.

70. **Nutrition Counseling,** unless covered elsewhere in this SPD.

71. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** unless covered elsewhere in this SPD.

72. **Orthognathic, Prognathic, and Maxillofacial Surgery.**

73. **Over-the-Counter Medication, Products, Supplies, or Devices,** unless covered elsewhere in this SPD.

74. **Palliative Foot Care.**

75. **Panniculectomy / Abdominoplasty,** unless determined by the Plan to be Medically Necessary.

76. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as, but not limited to, private rooms, televisions, telephones and guest trays. Services associated with aiding a patient in the home, such as a homemaker, domestic or maid service.

77. **Pharmacy Consultations.** Charges for or related to consultative information provided by a pharmacist regarding a Prescription order, including, but not limited to, information related to dosage instruction, drug interactions, side effects, and the like.

78. **Preventive / Routine Care Services,** unless covered elsewhere in this SPD. Excluded are immunizations required for travel and physical examinations needed or employment, insurance, or governmental licensing.

79. **Private Duty Nursing Services.**

80. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

81. **Return to Work / School:** Telephone or Internet consultations, or the completion of claim forms or forms necessary for a return to work or school.

82. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization, unless covered by the Plan in connection with Infertility Treatment.

83. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

84. **Sclerotherapy.**

85. **Self-Administered Services** or procedures that can be performed by the Covered Person without the presence of medical supervision.

86. **Services at No Charge or Cost:** Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

87. **Services Provided By a Close Relative or By a Family Member.** See the Glossary of Terms section of this SPD for a definition of Close Relative.

88. **Services Provided By a School.**

89. **Services Received as a Result of an Illegal Act.** Any Injury resulted from being arrested by, in custody of, being guarded by a law enforcement officer or under house arrest.

90. **Services Received Prior to Your Eligibility Effective Date or after the Termination Date.**

91. **Sex Change Operations** or any sex change related services including services for sexual transformation or sexual dysfunction or inadequacies.

92. **Sex Therapy.**

93. **Sexual Function:** Diagnostic service, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Drug Benefits section of this SPD) in connection with treatment for male or female impotence.

94. **Standby Surgeon Charges.**

95. **Surrogate Parenting and Gestational Carrier Services,** including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.

96. **Taxes:** Sales taxes and shipping and handling charges, unless covered elsewhere in this SPD.

97. **Telemedicine - Telephone or Internet Consultations.**

98. **Temporomandibular Joint Disorder (TMJ) Services:**

    - Diagnostic services.
    - Surgical treatment.
    - Non-surgical treatment (including intraoral devices or any other non-surgical method to alter occlusion and/or vertical dimension).

    This Plan does not cover orthodontic services or procedures, periodontal surgery, cast crowns, cast post or core, cast bridges, inlays or onlays, porcelain or resin laminate veneers, space maintainers, implants or any cosmetic dental procedures.

99. **Tobacco Addiction:** Diagnoses, services, treatment, or supplies related to addiction to or dependency on nicotine, unless covered elsewhere in this SPD.

100. **Transportation:** Transportation services that are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

101. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.

102. **Treatment for Conditions Covered by Workers' Compensation laws.**

103. **Varicose Vein Treatment of the Extremities.**

104. **Vision Care,** including eyeglasses or contact lenses unless covered elsewhere in this SPD.

105. **Vision Training,** eye exercises, orthoptics, or surgery performed to correct or improve myopia.

106. **Vitamins, Minerals, and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.

107. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning, and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

108. **Weekend Admissions** to Hospital confinement (admissions taking place after 3:00 pm on Fridays or before noon on Sundays) unless the admission is deemed an Emergency or is for care related to pregnancy that is expected to result in childbirth.

109. **Weight Control:** Treatment, services, or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling.

110. **Wigs (Cranial Prostheses), Toupees, Hairpieces, Hair Implants or Transplants, or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss, unless covered elsewhere in this SPD.

111. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else, such as the Covered Person's spouse or another family member, files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Employee has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal FMLA and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy, at no charge, of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Physician (i.e., Your Physician, nurse, midwife, or physician assistant) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain precertification. For information on precertification, contact Your plan administrator.

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- Americans With Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- Genetic Information Non-discrimination Act (GINA).

The Plan Sponsor has opted out of complying with the following federal regulations as is allowed by law for governmental or church group health plans:

- Mental Health Parity Act.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Newborns' and Mothers' Health Protection Act.

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care, or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations that it performs on behalf of this Plan.

This Plan agrees that it will Disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees, or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Human Resources, Certified Public Accountant, Enrollment Pre-Screeners

This list includes every Employee, class of Employees, or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy, and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;

- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a person to whom the CE discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical records, billing records, enrollment records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

Plan Sponsor means Your employer.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy, will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as, a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

ABA / IBI / Autism Spectrum Disorder therapy: Intensive behavioral therapy programs used to treat Autism Spectrum Disorder are often referred to as Intensive Behavioral Intervention (IBI), Early Intensive Behavioral Intervention (EIBI), or Applied Behavior Analysis (ABA). These interventions aim to reduce problem behaviors and develop alternative behaviors and skills in those with Autism Spectrum Disorder. In a typical therapy session, the Child is directed to perform an action. Successful performance of the task is rewarded with a positive reinforcer, while noncompliance or no response receives a neutral reaction from the therapist. For Children with maladaptive behaviors, plans are created to utilize the use of reinforcers to decrease problem behavior and increase more appropriate responses. Although once a component of the original Lovaas methodology, aversive consequences are no longer used. Parental involvement is considered essential to long-term treatment success; parents are taught to continue behavioral modification training when the Child is at home, and may sometimes act as the primary therapist.

Accident means an unexpected, unforeseen, and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, to for treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Advanced Imaging means the action or process of producing an image of a part of the body by radiographic techniques using high-end radiology such as MRA, MRI, CT, or PET scans and nuclear medicine.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic services.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation, or when deemed Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Ancillary Services means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency, including the following: ambulance services, anesthesiology, assistant surgeon services, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

Birthing Center means a legally operating institution or facility that is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse's Legal Guardianship; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes the Employee, spouse, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, stepchildren, and grandchildren.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to qualifying events.

Common-Law Marriage means a partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

Cosmetic Treatment means medical or surgical procedures that are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expense means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan.

Covered Person means an Employee or Dependent who is enrolled under this Plan.

Custodial Care means non-medical care given to a Covered Person, such as administering medication and assisting with personal hygiene or other Activities of Daily Living, rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce a disability or improve the condition of a Covered Person.

Deductible means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see the Eligibility and Enrollment section of this SPD.

Developmental Delays means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills. Developmental Delay may not necessarily have a history of birth trauma or other Illness that could be causing the impairment, such as a hearing problem, mental Illness, or other neurological symptoms or Illness.

Durable Medical Equipment means equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- It is generally is not useful to a person in the absence of an Illness or Injury.
- It is appropriate for use in the Covered Person's home.

A cochlear implant is not considered Durable Medical Equipment.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

Emergency means a serious medical condition, with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

member
~~**Employee**~~ – see the Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the date that coverage begins.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

Experimental, Investigational, or Unproven means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;
- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility means a facility including, but not limited to, a skilled nursing, rehabilitation, convalescent, or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full-time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: provide 24-hour-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; require compensation from its patients; admit patients only upon Physician orders; have an agreement to have a Physician's services available when needed; maintain adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provide the services to which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Gender Dysphoria means a disorder characterized by the following diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association:

Diagnostic criteria for adults and adolescents:

- A marked incongruence exists between one's experienced/expressed gender and one's assigned gender, of at least six months' duration, as manifested by at least two of the following:
  - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics).
  - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

  The condition must be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Diagnostic criteria for children:

- A marked incongruence exists between one's experienced/expressed gender and one's assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be the criterion shown in the first bullet below):
  - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - A strong preference for cross-gender roles in make-believe play or fantasy play.
  - A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
  - A strong preference for playmates of the other gender.
  - In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
  - A strong dislike of one's sexual anatomy.
  - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

  The condition must be associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

Home Health Care means a formal program of care and intermittent treatment that is: performed in the home; prescribed by a Physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or an Extended Care Facility stay or results in a shorter Hospital or Extended Care Facility stay; organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician that is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours per day, 7 days per week; is certified by Medicare as a Hospice Care Agency; and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services, medical social worker services, psychological and dietary counseling, Physician services, physical or occupational therapy, home health aide services, pharmacy services, and Durable Medical Equipment.

Hospital means a facility that:

- Is a licensed institution authorized to operate as a Hospital by the state in which it is operating; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, the term "Hospital" also includes Surgical Centers and Birthing Centers licensed by the states in which they operate.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is performed in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm-enhancement procedures; direct attempts to cause pregnancy by any means, including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas, including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Manipulation means the act, process, or instance of manipulating a body part by manual examination and treatment, such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

Maximum Benefit means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, substance use disorder, condition, or disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, or disease or its symptoms; and

- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Not more costly than an alternative drug, service(s), or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your Illness, Injury, disease, or symptoms

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

Mental Health Disorder means a disorder that is a clinically significant psychological syndrome associated with distress, dysfunction or Illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, Illness, or death.

Multiple Surgical Procedures means that more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, or too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliance means a brace, splint, cast, or other appliance that is used to support or restrain a weak or deformed part of the body, that is designed for repeated use, that is intended to treat or stabilize a Covered Person's Illness or Injury or improve function, and that is generally not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services, or supplies in a facility in which a patient is not registered as a bed patient and for whom room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this Plan: a doctor of medicine (MD), doctor of medical dentistry, including an oral surgeon (DMD), doctor of osteopathy (DO); doctor of podiatric medicine (DPM); doctor of dental surgery (DDS); doctor of chiropractic (DC); doctor of optometry (OPT). Subject to the limitations below, the term "Physician" also includes the following practitioner types: physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

Placed for Adoption / Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the WEST VOLUSIA HOSPITAL AUTHORITY Group Health Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom it is prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive / Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive / Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive / Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

Primary Care Physician means a Physician engaged in family practice, general practice, non-specialized internal medicine (i.e., one who works out of a family practice clinic), pediatrics, obstetrics/gynecology, or the treatment of mental health/substance use disorders. Generally, these Physicians provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners provide routine medical care; internists treat routine and complex conditions in adults; and pediatric practitioners treat Children.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified Provider means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

Specialist means a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians who are not considered Specialists include, but are not limited to, family practitioners, non-specializing internists, pediatricians, obstetricians/gynecologists, and mental health/substance use disorder treatment providers.

Specialty Drug means a Prescription drug used to treat complex, chronic or rare medical conditions (e.g. cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Specialty Drugs often require special handling (e.g. refrigeration) and ongoing clinical monitoring.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications.

Temporomandibular Joint Disorder (TMJ) means a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled means, as determined by the Plan in its sole discretion:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is Qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

Waiting Period means the period of time that must pass before coverage becomes effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan. Refer to the Eligibility and Enrollment section of this Plan to determine if a Waiting Period applies.

Walk-In Retail Health Clinics means health clinics located in retail stores, supermarkets, or pharmacies that provide a limited scope of preventive and/or clinical services to treat routine family Illnesses. Such a clinic must be operating under applicable state and local regulations and overseen by a Physician where required by law.

You / Your means the Employee.

City of DeLand

"The Athens of Florida"
www.deland.org

December 21, 2018

Mr. Andy Ferrari, Chairperson
West Volusia Hospital Authority
Attn: Eileen Long
P.O. Box 940
DeLand, FL 32721-0940

Re: Notice to Taxing Authority
Downtown DeLand Community Redevelopment Agency

Dear Mr. Ferrari:

Enclosed for your information is the "Notice to Taxing Authority" which provides notification pursuant to Section 163.346, Florida Statutes, of the City Commission's intent to adopt a resolution amending the Downtown DeLand Redevelopment Plan. A copy of the proposed resolution to be considered by the City Commission is available for inspection at the DeLand City Manager's office. The purpose of this amendment is to extend the expiration of the Redevelopment Plan until December 31, 2036.

The City Commission will be holding a public hearing regarding this matter on January 07, 2019, as outlined in the enclosed notice. If you have any questions after review of this information, please do not hesitate to contact me at (386) 626-7110.

Sincerely,

Mike Grebosz
Assistant City Manager

NOTICE TO TAXING AUTHORITY

Pursuant to Section 163.346, Florida Statutes, the City Commission of DeLand, Florida, does hereby give notice to each taxing authority, as that term is defined in Section 163.340(24), Florida Statutes, of its intention to adopt a resolution in accordance with Section 163.361, Florida Statutes, adopting an amendment to the Community Redevelopment Plan for the Downtown DeLand Redevelopment Area as originally adopted in June 1985, as amended by Resolution 92-20, Resolution 94-14, Resolution 94-30, Resolution 2005-38, Resolution 2008-61, and Resolution 2010-28. The purpose of the amendment is to extend the duration of the Community Redevelopment Plan from September 30, 2025 to December 31, 2036.

The Downtown DeLand Community Redevelopment Agency will consider the resolution at a public meeting on January 07, 2019 beginning at 6:30 p.m. and the City Commission will consider the resolution at a public meeting on January 07, 2019 beginning at 7:00 p.m., or as soon thereafter as possible, both at the City Commission Chambers located at 120 South Florida Avenue, DeLand, Florida.

If you have any questions, please contact Mike Grebosz, Assistant City Manager at (386) 626-7110. A copy of the proposed resolution is available for review at the DeLand City Manager's office.

West Volusia Hospital Authority
Financial Statements
November 30, 2018

Dreggors, Rigsby & Teal, P.A.
Advisors for Life
Certified Public Accountants | Registered Investment Advisor

1006 N. Woodland Boulevard ■ DeLand, FL 32720
(386) 734-9441 www.drtcpa.com

James H. Dreggors, CPA
Ann J. Rigsby, CPA/CFP™
Parke S. Teal, CPA/PFS (1954-2011)

Ronald J. Cantlay, CPA/CFP™
Robin C. Lennon, CPA
John A. Powers, CPA

To the Board of Commissioners
West Volusia Hospital Authority
P. O. Box 940
DeLand, FL 32720-0940

Management is responsible for the accompanying balance sheet (modified cash basis) of West Volusia Hospital Authority, as of November 30, 2018 and the related statement of revenues and expenditures - budget and actual (modified cash basis) for the month then ended and year-to-date, in accordance with accounting principles generally accepted in the United States of America. We have performed a compilation engagement in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the financial statements nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on these financial statements.

The accompanying supplemental information contained in Schedules I and II is presented for purposes of additional analysis and is not a required part of the basic financial statements. This information is the representation of management. The information was subject to our compilation engagement; however, we have not audited or reviewed the supplementary information and, accordingly, do not express an opinion, a conclusion, nor provide any assurance on such supplementary information.

Management has elected to omit substantially all of the disclosures required by accounting principles generally accepted in the United States of America. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the Authority's financial position, results of operations, and cash flows. Accordingly, the financial statements are not designed for those who are not informed about such matters.

We are not independent with respect to West Volusia Hospital Authority.

Dreggors, Rigsby & Teal, P.A.
Certified Public Accountants
DeLand, FL

December 07, 2018

West Volusia Hospital Authority
Balance Sheet
Modified Cash Basis
November 30, 2018

Assets

Current Assets		
Petty Cash	$	100.00
Intracoastal Bank - Money Market		6,783,614.06
Intracoastal Bank - Operating		2,019,856.22
Mainstreet Community Bank - MM		2,074,741.25
Taxes Receivable		92,073.00
Total Current Assets		**10,970,384.53**
Fixed Assets		
Land		145,000.00
Buildings		422,024.71
Building Improvements		350,822.58
Equipment		251.78
Total Fixed Assets		**918,099.07**
Less Accum. Depreciation		(296,440.64)
Total Net Fixed Assets		**621,658.43**
Other Assets		
Deposits		2,000.00
Total Other Assets		**2,000.00**
Total Assets		**11,594,042.96**

Liabilities and Net Assets

Current Liabilities		
Security Deposit		5,110.00
Deferred Revenue		88,660.00
Total Current Liabilities		**93,770.00**
Net Assets		
Unassigned Fund Balance		9,847,034.14
Restricted Fund Balance		208,000.00
Nonspendable Fund Balance		621,658.43
Net Income Excess (Deficit)		823,580.39
Total Net Assets		**11,500,272.96**
Total Liabilities and Net Assets	$	**11,594,042.96**

West Volusia Hospital Authority
Statement of Revenue and Expenditures
Modified Cash Basis
Budget and Actual
For the 1 Month and 2 Months Ended November 30, 2018

	Annual Budget	Current Period Actual	Year To Date Actual	Budget Balance
Revenue				
Ad Valorem Taxes	20,194,000	2,148,375	2,154,870	18,039,130
Investment Income	55,000	6,002	12,491	42,509
Rental Income	70,968	5,692	11,384	59,584
Total Revenue	**20,319,968**	**2,160,069**	**2,178,745**	**18,141,223**
Healthcare Expenditures				
Adventist Health Systems	5,848,544	65,487	121,312	5,727,232
Northeast Florida Health Services	1,700,603	136,226	147,520	1,553,083
Specialty Care	4,375,000	175,648	258,546	4,116,454
County Medicaid Reimbursement	2,385,000	195,966	391,933	1,993,067
The House Next Door	120,000	11,238	11,238	108,762
The Neighborhood Center	70,000	8,300	8,300	61,700
Community Life Center Outreach Services	20,000	550	550	19,450
Rising Against All Odds	235,000	14,665	14,665	220,335
Community Legal Services	76,931	4,127	4,127	72,804
Hispanic Health Initiatives	75,000	3,900	3,900	71,100
Florida Dept of Health Dental Svcs	200,000	18,483	18,483	181,517
Good Samaritan	60,000	0	0	60,000
Stewart Marchman - ACT	925,336	109,039	109,039	816,297
Health Start Coalition of Flagler & Volusia	142,359	5,313	5,313	137,046
H C R A	819,612	0	0	819,612
Other Healthcare Costs	1,095,090	0	0	1,095,090
Total Healthcare Expenditures	**18,148,475**	**748,942**	**1,094,926**	**17,053,549**
Other Expenditures				
Advertising	5,000	147	2,357	2,643
Annual Independent Audit	16,000	0	0	16,000
Building & Office Costs	6,500	80	396	6,104
General Accounting	68,100	5,657	5,657	62,443
General Administrative	65,100	3,891	3,891	61,209
Legal Counsel	70,000	2,180	3,420	66,580
Special Accounting	5,000	0	0	5,000
City of DeLand Tax Increment District	100,000	0	0	100,000
Tax Collector & Appraiser Fee	603,880	113,743	113,861	490,019
TPA Services	500,000	75,292	102,542	397,458
Eligibility / Enrollment	30,000	1,785	1,785	28,215
Healthy Communities	72,036	4,973	4,973	67,063
Application Screening				
Application Screening - THND	317,872	15,812	15,812	302,060
Application Screening - RAAO	34,005	5,184	5,184	28,821
Application Screening - SMA	3,000	0	0	3,000
Workers Compensation Claims	25,000	0	0	25,000
Other Operating Expenditures	250,000	149	361	249,639
Total Other Expenditures	**2,171,493**	**228,893**	**260,239**	**1,911,254**
Total Expenditures	20,319,968	977,835	1,355,165	18,964,803
Excess (Deficit)	**0**	**1,182,234**	**823,580**	**(823,580)**

See Accountants' Compilation Report

West Volusia Hospital Authority
Schedule I - Healthcare Expenditures
Modified Cash Basis
Budget and Actual
For the 1 Month and 2 Months Ended November 30, 2018

	Annual Budget	Current Period Actual	Year To Date Actual	Budget Balance
Healthcare Expenditures				
Adventist Health Systems				
Florida Hospital DeLand	2,811,772	38,577	94,402	2,717,370
Florida Hospital Fish Memorial	2,811,772	26,910	26,910	2,784,862
Florida Hospital DeLand - Physicians	112,500	0	0	112,500
Florida Hospital Fish - Physicians	112,500	0	0	112,500
Northeast Florida Health Services				
NEFHS - Pharmacy	752,281	62,667	62,667	689,614
NEFHS - Obstetrics	30,000	5,776	5,896	24,104
NEFHS - Primary Care	918,322	67,784	78,957	839,365
Specialty Care				
Specialty Care Services	4,375,000	155,504	224,650	4,150,350
Laboratory Services	0	20,144	33,896	(33,896)
County Medicaid Reimbursement	2,385,000	195,966	391,933	1,993,067
Florida Dept of Health Dental Svcs	200,000	18,483	18,483	181,517
Good Samaritan				
Good Samaritan Health Clinic	30,000	0	0	30,000
Good Samaritan Dental Clinic	30,000	0	0	30,000
Global Healthcare System				
The House Next Door	120,000	11,238	11,238	108,762
The Neighborhood Center	70,000	8,300	8,300	61,700
Community Life Center Outreach Services	20,000	550	550	19,450
Rising Against All Odds	235,000	14,665	14,665	220,335
Community Legal Services	76,931	4,127	4,127	72,804
Hispanic Health Initiatives	75,000	3,900	3,900	71,100
Stewart Marchman - ACT				
SMA - Homeless Program	75,336	9,142	9,142	66,194
SMA - Residential Treatment	550,000	76,027	76,027	473,973
SMA - Baker Act - Match	300,000	23,869	23,869	276,131
Health Start Coalition of Flagler & Volusia				
HSCFV - Outreach	68,859	1,237	1,237	67,622
HSCFV - Fam Services	73,500	4,076	4,076	69,424
HCRA				
H C R A - In County	400,000	0	0	400,000
H C R A - Outside County	419,612	0	0	419,612
Other Healthcare Costs	1,095,090	0	0	1,095,090
Total Healthcare Expenditures	**18,148,475**	**748,942**	**1,094,925**	**17,053,550**

West Volusia Hospital Authority
Schedule II - Statement of Revenue and Expenditures
Modified Cash Basis
For the 1 Month and 2 Months Ended November 30, 2018 and November 30, 2017

	1 Month Ended November 30, 2018	1 Month Ended November 30, 2017	2 MonthsEnded November 30, 2018	2 Months Ended November 30, 2017
Revenue				
Ad Valorem Taxes	2,148,375	2,790,032	2,154,870	2,791,463
Investment Income	6,002	1,917	12,491	4,331
Rental Income	5,692	5,776	11,384	11,384
Other Income	0	203	0	203
Total Revenue	2,160,069	2,797,928	2,178,745	2,807,381
Healthcare Expenditures				
Adventist Health Systems	65,487	433,175	121,312	433,106
Northeast Florida Health Services	136,226	(810)	147,520	147,905
Specialty Care	175,648	22,404	258,546	290,259
County Medicaid Reimbursement	195,966	371,305	391,933	371,305
The House Next Door	11,238	3,784	11,238	10,041
The Neighborhood Center	8,300	2,883	8,300	7,100
Community Life Center Outreach Services	550	0	550	0
Rising Against All Odds	14,665	15,106	14,665	24,900
Community Legal Services	4,127	(2,240)	4,127	3,421
Hispanic Health Initiatives	3,900	3,425	3,900	12,800
Florida Dept of Health Dental Svcs	18,483	1,360	18,483	28,313
Good Samaritan	0	1,830	0	4,553
Stewart Marchman - ACT	109,039	51,831	109,039	74,749
Health Start Coalition of Flagler & Volusia	5,313	4,925	5,313	16,385
H C R A	0	(43,778)	0	0
Total Healthcare Expenditures	**748,942**	**865,200**	**1,094,926**	**1,424,837**
Other Expenditures				
Advertising	147	(2,082)	2,357	447
Building & Office Costs	80	214	396	719
General Accounting	5,657	2,564	5,657	3,367
General Administrative	3,891	(639)	3,891	5,174
Legal Counsel	2,180	(650)	3,420	11,120
City of DeLand Tax Increment District	0	69,746	0	69,746
Tax Collector & Appraiser Fee	113,743	56,972	113,861	56,986
TPA Services	75,292	27,250	102,542	54,500
Eligibility / Enrollment	1,785	0	1,785	0
Healthy Communities	4,973	(1,918)	4,973	4,865
Application Screening				
Application Screening - THND	15,812	3,834	15,812	15,812
Application Screening - RAAO	5,184	(45)	5,184	1,152
Application Screening - SMA	0	539	0	539
Other Operating Expenditures	149	309	361	351
Total Other Expenditures	**228,893**	**156,094**	**260,239**	**224,778**
Total Expenditures	977,835	1,021,294	1,355,165	1,649,615
Excess (Deficit)	**1,182,234**	**1,776,634**	**823,580**	**1,157,766**

See Accountants' Compilation Report

West Volusia Hospital Authority
Financial Statements
December 31, 2018

Dreggors, Rigsby & Teal, P.A.
Advisors for Life
Certified Public Accountants | Registered Investment Advisor

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James H. Dreggors, CPA
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Robin C. Lennon, CPA
John A. Powers, CPA

To the Board of Commissioners
West Volusia Hospital Authority
P. O. Box 940
DeLand, FL 32720-0940

Management is responsible for the accompanying balance sheet (modified cash basis) of West Volusia Hospital Authority, as of December 31, 2018 and the related statement of revenues and expenditures - budget and actual (modified cash basis) for the month then ended and year-to-date, in accordance with accounting principles generally accepted in the United States of America. We have performed a compilation engagement in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the financial statements nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on these financial statements.

The accompanying supplemental information contained in Schedules I and II is presented for purposes of additional analysis and is not a required part of the basic financial statements. This information is the representation of management. The information was subject to our compilation engagement; however, we have not audited or reviewed the supplementary information and, accordingly, do not express an opinion, a conclusion, nor provide any assurance on such supplementary information.

Management has elected to omit substantially all of the disclosures required by accounting principles generally accepted in the United States of America. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the Authority's financial position, results of operations, and cash flows. Accordingly, the financial statements are not designed for those who are not informed about such matters.

We are not independent with respect to West Volusia Hospital Authority.

Dreggors, Rigsby & Teal, P.A.

Dreggors, Rigsby & Teal, P.A.
Certified Public Accountants
DeLand, FL

January 02, 2019

West Volusia Hospital Authority
Balance Sheet
Modified Cash Basis
December 31, 2018

Assets

Current Assets		
Petty Cash	$	100.00
Intracoastal Bank - Money Market		10,789,070.18
Intracoastal Bank - Operating		2,708,253.53
Mainstreet Community Bank - MM		10,477,942.28
Taxes Receivable		92,073.00
Total Current Assets		**24,067,438.99**
Fixed Assets		
Land		145,000.00
Buildings		422,024.71
Building Improvements		350,822.58
Equipment		251.78
Total Fixed Assets		**918,099.07**
Less Accum. Depreciation		(296,440.64)
Total Net Fixed Assets		**621,658.43**
Other Assets		
Deposits		2,000.00
Total Other Assets		**2,000.00**
Total Assets		**24,691,097.42**

Liabilities and Net Assets

Current Liabilities		
Security Deposit		5,110.00
Deferred Revenue		88,660.00
Total Current Liabilities		**93,770.00**
Net Assets		
Unassigned Fund Balance		9,847,034.14
Restricted Fund Balance		208,000.00
Nonspendable Fund Balance		621,658.43
Net Income Excess (Deficit)		13,920,634.85
Total Net Assets		**24,597,327.42**
Total Liabilities and Net Assets	**$**	**24,691,097.42**

West Volusia Hospital Authority
Schedule I - Healthcare Expenditures
Modified Cash Basis
Budget and Actual
For the 1 Month and 3 Months Ended December 31, 2018

	Annual Budget	Current Period Actual	Year To Date Actual	Budget Balance
Healthcare Expenditures				
Adventist Health Systems				
Florida Hospital DeLand	2,811,772	128,647	223,049	2,588,723
Florida Hospital Fish Memorial	2,811,772	140,221	167,131	2,644,641
Florida Hospital DeLand - Physicians	112,500	0	0	112,500
Florida Hospital Fish - Physicians	112,500	0	0	112,500
Northeast Florida Health Services				
NEFHS - Pharmacy	752,281	62,667	125,333	626,948
NEFHS - Obstetrics	30,000	7,708	13,604	16,396
NEFHS - Primary Care	918,322	83,702	162,659	755,663
Specialty Care	4,375,000	371,770	630,316	3,744,684
County Medicaid Reimbursement	2,385,000	195,966	587,899	1,797,101
Florida Dept of Health Dental Svcs	200,000	21,027	39,510	160,490
Good Samaritan				
Good Samaritan Health Clinic	30,000	0	0	30,000
Good Samaritan Dental Clinic	30,000	0	0	30,000
The House Next Door	120,000	9,463	20,701	99,299
The Neighborhood Center	70,000	7,775	16,075	53,925
Community Life Center Outreach Services	20,000	0	550	19,450
Rising Against All Odds	235,000	13,200	27,865	207,135
Community Legal Services	76,931	2,571	6,698	70,233
Hispanic Health Initiatives	75,000	2,825	6,725	68,275
Stewart Marchman - ACT				
SMA - Homeless Program	75,336	8,218	17,360	57,976
SMA - Residential Treatment	550,000	89,703	165,730	384,270
SMA - Baker Act - Match	300,000	20,520	44,389	255,611
Health Start Coalition of Flagler & Volusia				
HSCFV - Outreach	68,859	636	1,873	66,986
HSCFV - Fam Services	73,500	6,929	11,005	62,495
HCRA				
H C R A - In County	400,000	4,830	4,830	395,170
H C R A - Outside County	419,612	5,550	5,550	414,062
Other Healthcare Costs	1,095,090	0	0	1,095,090
Total Healthcare Expenditures	**18,148,475**	**1,183,928**	**2,278,852**	**15,869,623**

West Volusia Hospital Authority
Statement of Revenue and Expenditures
Modified Cash Basis
Budget and Actual
For the 1 Month and 3 Months Ended December 31, 2018

	Annual Budget	Current Period Actual	Year To Date Actual	Budget Balance
Revenue				
Ad Valorem Taxes	20,194,000	14,648,202	16,803,072	3,390,928
Investment Income	55,000	8,867	21,358	33,642
Rental Income	70,968	5,692	17,076	53,892
Total Revenue	**20,319,968**	**14,662,761**	**16,841,506**	**3,478,462**
Healthcare Expenditures				
Adventist Health Systems	5,848,544	268,868	390,180	5,458,364
Northeast Florida Health Services	1,700,603	154,076	301,596	1,399,007
Specialty Care	4,375,000	371,770	630,316	3,744,684
County Medicaid Reimbursement	2,385,000	195,966	587,899	1,797,101
The House Next Door	120,000	9,463	20,701	99,299
The Neighborhood Center	70,000	7,775	16,075	53,925
Community Life Center Outreach Services	20,000	0	550	19,450
Rising Against All Odds	235,000	13,200	27,865	207,135
Community Legal Services	76,931	2,571	6,698	70,233
Hispanic Health Initiatives	75,000	2,825	6,725	68,275
Florida Dept of Health Dental Svcs	200,000	21,027	39,510	160,490
Good Samaritan	60,000	0	0	60,000
Stewart Marchman - ACT	925,336	118,441	227,479	697,857
Health Start Coalition of Flagler & Volusia	142,359	7,565	12,878	129,481
H C R A	819,612	10,380	10,380	809,232
Other Healthcare Costs	1,095,090	0	0	1,095,090
Total Healthcare Expenditures	**18,148,475**	**1,183,927**	**2,278,852**	**15,869,623**
Other Expenditures				
Advertising	5,000	0	2,357	2,643
Annual Independent Audit	16,000	0	0	16,000
Building & Office Costs	6,500	1,202	1,598	4,902
General Accounting	68,100	7,321	12,978	55,122
General Administrative	65,100	2,573	6,464	58,636
Legal Counsel	70,000	4,060	7,480	62,520
Special Accounting	5,000	0	0	5,000
City of DeLand Tax Increment District	100,000	0	0	100,000
Tax Collector & Appraiser Fee	603,880	292,960	406,821	197,059
TPA Services	500,000	44,072	146,614	353,386
Eligibility / Enrollment	30,000	1,575	3,360	26,640
Healthy Communities	72,036	7,513	12,486	59,550
Application Screening				
Application Screening - THND	317,872	15,812	31,624	286,248
Application Screening - RAAO	34,005	4,224	9,408	24,597
Application Screening - SMA	3,000	0	0	3,000
Workers Compensation Claims	25,000	0	0	25,000
Other Operating Expenditures	250,000	468	829	249,171
Total Other Expenditures	**2,171,493**	**381,780**	**642,019**	**1,529,474**
Total Expenditures	20,319,968	1,565,707	2,920,871	17,399,097
Excess (Deficit)	**0**	**13,097,054**	**13,920,635**	**(13,920,635)**

See Accountants' Compilation Report

West Volusia Hospital Authority
Schedule II - Statement of Revenue and Expenditures
Modified Cash Basis
For the 1 Month and 3 Months Ended December 31, 2018 and December 31, 2017

	1 Month Ended December 31, 2018	1 Month Ended December 31, 2017	3 MonthsEnded December 31, 2018	3 Months Ended December 31, 2017
Revenue				
Ad Valorem Taxes	14,648,202	13,757,414	16,803,072	16,548,877
Investment Income	8,867	4,318	21,358	8,648
Rental Income	5,692	5,692	17,076	17,076
Other Income	0	0	0	203
Total Revenue	14,662,761	13,767,424	16,841,506	16,574,804
Healthcare Expenditures				
Adventist Health Systems	268,868	1,395,381	390,180	1,828,486
Northeast Florida Health Services	154,076	76,333	301,596	224,238
Specialty Care	371,770	289,939	630,316	580,197
County Medicaid Reimbursement	195,966	185,652	587,899	556,957
The House Next Door	9,463	8,501	20,701	18,541
The Neighborhood Center	7,775	8,200	16,075	15,300
Community Life Center Outreach Services	0	0	550	0
Rising Against All Odds	13,200	17,650	27,865	42,550
Community Legal Services	2,571	2,943	6,698	6,364
Hispanic Health Initiatives	2,825	8,553	6,725	21,353
Florida Dept of Health Dental Svcs	21,027	21,532	39,510	49,845
Good Samaritan	0	4,089	0	8,642
Stewart Marchman - ACT	118,441	78,437	227,479	153,187
Health Start Coalition of Flagler & Volusia	7,565	12,697	12,878	29,082
H C R A	10,380	6,770	10,380	6,770
Total Healthcare Expenditures	1,183,927	2,116,677	2,278,852	3,541,512
Other Expenditures				
Advertising	0	0	2,357	447
Building & Office Costs	1,202	996	1,598	1,715
General Accounting	7,321	7,243	12,978	10,610
General Administrative	2,573	5,229	6,464	10,403
Legal Counsel	4,060	3,050	7,480	14,170
City of DeLand Tax Increment District	0	0	0	69,746
Tax Collector & Appraiser Fee	292,960	275,146	406,821	332,132
TPA Services	44,072	0	146,614	54,500
Eligibility / Enrollment	1,575	0	3,360	0
Healthy Communities	7,513	7,341	12,486	12,205
Application Screening				
Application Screening - THND	15,812	15,812	31,624	31,624
Application Screening - RAAO	4,224	960	9,408	2,112
Application Screening - SMA	0	612	0	1,151
Other Operating Expenditures	468	0	829	351
Total Other Expenditures	381,780	316,389	642,019	541,166
Total Expenditures	1,565,707	2,433,066	2,920,871	4,082,678
Excess (Deficit)	13,097,054	11,334,358	13,920,635	12,492,126

See Accountants' Compilation Report

LEGAL UPDATE MEMORANDUM

TO: WVHA Board of Commissioners

DATE: January 8, 2019

FROM: Theodore W. Small, Jr.

RE: West Volusia Hospital Authority - Update for January 17, 2019 Regular Meeting

Summarized below are updates on active legal matters/issues for which some new information has become available since my last legal update dated September 27, 2018. This Memorandum will not reflect updates on matters resolved by a final vote of the Board and thereby already summarized in the 10/18/18 and 11/15/18 Meeting Minutes.

I. Annual Overview of Funding Agreements or other Contracts:

Each Board member is responsible for making his or her own independent determination about whether the terms of a particular contract are consistent with the public interest. Counsel, as well as the accounting and administrative team at DRT, PA, are available to answer your questions and offer counsel about accounting and business or legal matters, each respectively; but, the Board retains the ultimate authority to approve or disapprove the terms of all proposed agreements after due consultation. For your convenience, the following is a listing of the major contracts and funding agreements between the Authority and other entities with notation of termination dates, if any. **Please note well in advance that the Indigent Care Reimbursement Agreement with the Hospitals is scheduled to terminate effective September 30, 2020.**

Annual Health Care or Access to Health Care Funding Agreements, 2018-19

A. Community Legal Services, Inc. Medical-Legal Partnership program.
B. Community Life Center Outreach Services, Inc.
C. Good Samaritan Clinic -Primary and General Dental (Voluntarily Terminated)
D. Healthy Communities – Kidcare Outreach
E. Hispanic Health Initiatives, Inc.'s Taking Care of My Health
F. Northeast Florida Health Services, d/b/a Family Health Source FHS--Clinics
G. Northeast Florida Health Services, d/b/a Family Health Source FHS—Pharmacy
H. Northeast Florida Health Services, d/b/a Family Health Source FHS—Prenatal
I. Rising Against All Odds, Inc. -- HIV/AIDS Outreach and Case Management
J. Stewart-Marchman-Act (SMA) – Baker Act Match
K. SMA – ARNP @ The House Next Door
L. SMA – Homeless Program
M. SMA—Level II Residential Treatment
N. The Healthy Start --Access to Healthcare Services—SMA Outreach
O. The Healthy Start –Family Services Coordinator—Deltona

P. The House Next Door – Mental Health Services
Q. The Neighborhood Center of West Volusia "Access to Care"
R. Volusia County Health Department—Florida Department of Health (Dental Care)

Hospital (Florida Hospital DeLand (FHD), Florida Hospital Fish Memorial (FHFM)) Agreements

A. Eighth Amendment to the Indigent Care Reimbursement Agreement (effective 9/30/2000; termination 9/30/2020). This agreement authorizes reimbursement for certain specified dialysis services and continues previously established reimbursement rates at 105% of Medicare rates for Health Card members to receive inpatient care at hospitals and 125% of Medicare rates for Health Card members to receive outpatient care at hospitals. WVHA's willingness to redirect payments under these contracts to the State of Florida facilitates the Hospitals' receipt of matching funding through various State of Florida/ACHA LIP programs.
    1. $800,000 Restricted Cash Account (a/k/a "Additional Charity Care Patient Reimbursement Amount") terminated on 9/30/2010 pursuant to Amendment dated 7/31/2003.
    2. $333,333 "Additional Indigent/Charity Care Reimbursement" terminated on 9/30/2010, paid for 6 years based on record motion but no final written contract.
B. Thirteenth Addendum to the Primary Care Physicians Indigent Hospital Patient Program Reimbursement Agreement (renewed annually since 2006)

HCRA (Hospital Coverage and Physician Indigent Hospital Patient Program Reimbursement Agreement)

A. Second Amended HCRA dated 9/23/2010, terminable at will by either party upon 60 days written notice.
    1) Establishes reimbursement rate consistent with HCRA guidelines, as opposed to 105% of Medicare rate (except for adult psychiatric and medical device implants) which was agreed in prior agreements dated 11/20/2008 and 4/19/2007.

Administrative Services

A. UMR, Inc. (f/k/a POMCO, Inc. dated 1/1/2016 (Third Party Administrator services) with a term of 3 years until December 31, 2018. This Administrative Agreement contains an option for WVHA to renew for an initial one year term with subsequent one year renewals becoming automatic unless or terminable by WVHA upon 90-days written notice. Because neither party notified of termination and the Board voted to renew the Agreement, counsel notified UMR that WVHA would rely upon the automatic renewal provision until ongoing negotiations are concluded concerning certain provisions as counsel summarized in an 11/15/18 email.
B. Eligibility Determination Services, effective 10/1/2018, renewable on annual basis.
C. Rising Against All Odds, Inc. – Health Card Enrollment and Retention, effective 10/1/2018, renewable on annual basis.
D. Dreggors, Rigsby & Teal, P.A. dated 9/27/2012 (accounting services), is terminable at will by either party upon 90 days written notice.

E. Dreggors, Rigsby & Teal, P.A. dated 9/27/2012 (administrative services), is terminable at will by either party upon 90 days written notice.
F. Law Office Of Theodore W. Small, P.A. dated 11/2006 (outside legal counsel), terminable at will by Board
G. James Moore and Co., P.L. (audit of financial statements) was signed September, 2015 for three years through September 30, 2017 and then renewed by mutual agreement for one 2 year term through September 30, 2019, and then may be renewed for 3 additional 1 year terms with 60-days' notice.

Real Property Agreements

a. Lease Agreement between West Volusia Hospital Authority and Northeast Florida Health Services, Inc. effective 8/31/2010, terminating on September 30, 2020 re: WVHA-owned premises at 842, 844 and 846 West Plymouth Avenue. Pursuant to a renewal agreement effective October 1, 2015, NFHS exercised one of its two five-year renewal options under the Lease Agreement. NFHS may exercise the second option by notifying WVHA of its exercise at least 60 days before the September 30, 2020 termination date.

II. Negotiations with UMR for TPA Services for Renewal Agreement.

After reviewing with the Board at the November meeting the status of negotiations with UMR on a final renewal agreement, counsel has continued to pursue a mutually acceptable agreement on several concerning provisions such as a dramatic narrowing of UMR's obligation to indemnify WVHA for lawsuits caused by its own negligence; prior consultation before contracting with third parties and engaging in tax dispute and other litigation on behalf of WVHA; and clarifications of the services included and excluded in the agreed base fees. On November 26th, counsel notified UMR's client representative, Mr. Jacobs as follows:

> Please note that if your contact team and I are able to get to something that we can mutually recommend by December 6th, then I could request that Ms. Long notice a special meeting for the Board to meet and approve a renewal agreement in a public meeting on December 20th. If we cannot get to that point, then we will need to work out some way to continue services under the automatic renewal provision within our existing Administrative Agreement (2016). The obvious problem with continuing under that agreement is the fact that we have both taken steps to transition staffing and payment for Health Card application processing to The House Next Door effective January 1, 2019. If we cannot get to a win-win on a renewal agreement by December 6 and need to continue under the existing Administrative Agreement past December 31, 2018, I would propose that we just agree that UMR would bill us for ongoing claims processing services based on renewal price terms until we can finalize all other terms.

Later it was agreed during a November 28th conference call and subsequent email exchanges that UMR's contract team would not be able to complete their review in the required time frames and that the parties would need to continue services and payment as recommended until a final renewal agreement could be reached. On January 4th, UMR's contracting team finally responded to counsel's December 10th mark-up of the 3rd draft and returned a proposed 4th draft of the renewal agreement. Counsel returned that 4th draft with comments on January

7th. Counsel has shared UMR's 4th draft and counsel's mark-up with DRT and will notify the Board via email if an agreement becomes ready for Board consideration and potential approval at the January Board meeting.

III. Discussions with EMPros Re: Restructuring Nature of Primary Care Physicians Indigent Hospital Patient Program Reimbursement Agreement (2006), as amended.

As proposed during the November 2018 Regular Meeting, Ms. Maureen France organized a joint meeting on December 11, 2018 at Florida Hospital DeLand with herself, EMPros President, Charles D. Duba, MD, EMPros Regional Operations Coordinator, Kristin McCabe-Kline, MD, FHD CFO, Kyle Glass (FHFM CFO, Eric Ostarly was expected but unable to attend). The discussion lasted about one and a half hours and focused principally on sharing background on 1. how the underlying 2006 Agreement which is subject to renewal each year, is a separate and distinct agreement from the 2000 Omnibus Agreement concerning the sale of the Hospital to Adventist, which is a 20 year agreement that is set to expire in September, 2020; 2. Why the 2006 Agreement was structured between WVHA and the Hospitals in 2006 without EMPros as a party; 3. how EMPros contracted with the Hospitals year after year without even becoming aware that the pool of monies it was being paid for providing physicians to staff the Hospitals' ERs was based on funding received from WVHA; 4. how the recent changes in federal and state programs that otherwise reimburse EMPros services and also the approximate 10% increases in qualified Health Card patients, is now motivating EMPros to seek more reimbursements to avoid a reduction in the quality of services available to all ER patients; 5. why EMPros would prefer to negotiate a reimbursement contract directly with WVHA as opposed to having the Hospitals as intermediaries for whatever reimbursements are provided by WVHA, and how it would be willing to propose multiple options for a restructured agreement including being contracted as specialists in the UMR network, negotiating a higher per patient amount which is adjusted for inflation from the amount agreed to in the 2006 Agreement, or a flat rate overall annual reimbursement amount to make the overall funding predictable to WVHA and cut down on paperwork on both sides; 6. why the Hospitals would prefer not to remain as intermediaries and may be willing to ask for less monies to reimburse the Hospitals for the separate category of inpatient physician services which is currently covered under the same 2006 Agreement and often leads to depletion of reimbursements that are available to EMPros before the WVHA funding year. Counsel emphasized to those gathered that the option of including EMPros as specialists is impractical on a number of levels, including the fact that specialty care network is managed, contracted and owned by UMR, not WVHA and restructuring finally settled WVHA policies that establish a PCP referral for all specialty services reimbursed under that network. The meeting concluded with EMPros taking on responsibility for coming up with a proposal that clearly and specifically explains what it wants to be paid and why those amounts are justified based on comparisons with the overall marketplace.

IV. Downtown DeLand CRA: Notice of Amendment to Extend CRA Expiration from September 30, 2025 to December 31, 2036.

By registered mail letter dated December 21, 2018, the City of DeLand sent the required 15-day

notice of its intention to consider at its public meeting on January 7, 2019, a resolution to extend the expiration of the Downtown DeLand CRA from September 30, 2025 to December 31, 2036. According to Ms. Long, DRT did not receive the letter until January 4th while she was out of the office and she immediately forwarded it to the Board and counsel on January 7th. Although legally sufficient, this notice did not give WVHA adequate time to meet and determine if it wanted to authorize counsel to express an objection to the proposed extension on the same policy grounds that the Florida Legislature established a statutory exemption of all hospital districts from being taxed to support any new CRAs established after 2016. Based on a preliminary review, it does not appear that the 2016 exemption legislation addresses cases where, as here, an preexisting CRA (originally established in 1985) is extending the time frame for its existence and thereby ability to levy taxes on WVHA, which was established to utilize its tax revenues for health care or access to health care, not community redevelopment.

Counsel spoke with City of DeLand Attorney, Darren Elkind in advance of last evening's City of DeLand meeting and explained the inadequacy of the notice to give WVHA time to meet and consider whether it desired to make any such objection. Attorney Elkind agreed to discuss the matter with the City Manager and indicated that WVHA might want to meet and consider whether it nevertheless desires to ask for an exemption from the extended period from the levy of taxes to support the Downtown DeLand CRA, or any variation of such a request, so that it can be considered by the City of DeLand at a future meeting.

V. WVHA Health Card Program Eligibility Guidelines. [*See new info. in italics and bold*] *[Refer back to Legal Update Memorandum dated 4/9/14, 7/19/14, 9/17/14, 11/12/14, 2/11/15, 6/10/2015, 10/7/15, 11/11/15, 3/9/16, 4/12/16 and 5/9/17 for additional background details.]*

From the inception, the Guidelines were adopted from a legal perspective to establish uniform, fair and non-discriminatory standards to comply with the Enabling Legislation's requirement that tax dollars are spent on primarily individuals who are both "residents" of the Tax District and who are "indigent" as defined within the Guidelines.

It is noteworthy that currently the Guidelines are utilized by WVHA in two distinct ways which are often confused by providers, potential providers and applicants for funding:

1. First, they are utilized by WVHA's Eligibility Determination provider, currently The House Next Door, as the governing rules for determining who is eligible to receive a WVHA Health Card. Once deemed eligible, THND transmits a listing to the Third Party Administrator, currently UMR, and UMR mails the eligible beneficiary a Health Card (effective usually for 6 months) which automatically makes them eligible to receive hospital care, primary care, dental care, specialty care and pharmacy benefits at any provider who has signed a funding agreement to provide such services to those who are currently enrolled in the Health Card Program;
2. Second, the Guidelines are incorporated in whole or part as the governing rules for a funded agency to qualify some of their individual clients to become eligible for WVHA reimbursement (at the contracted rate) for services at that agency only. Even though these individuals are <u>generally</u> required to provide the same information, including proof that they

have applied for the ACA and that they are not qualified for Medicaid or other affordable private health insurance, the individuals who qualify through these funded agencies do not receive a Health Card and therefore are NOT automatically eligible to receive other healthcare services available at other funded agencies, the hospitals, specialty care providers, pharmacy benefits, etc.

Board members should begin anticipating the annual EG review process that the Board approved in 2017. That process will start with a presentation by THND of a compilation of proposed changes in March and then after Board review, deliberation and voting by May Regular Meeting, the newly amendments would take effect in June, 2019; provided however, the Board would consider amending the EGs more frequently than annually where it is demonstrated by UMR and/or other proposers that that such exceptional action is necessary to fulfill the public purposes of WVHA.

VI. Formal Notice of Potential Claim for Damages against WVHA corporately and Chair Ferrari individually by Travis McBride and Central Florida Mental Health

[Refer back to Legal Update Memorandum dated 6/10/15, 8/12/15 and 3/6/18 for additional background details.]

The Authority retained counsel several years ago to vigorously contest litigation that was threatened by Travis McBride and Central Florida Mental Health Associates, LLC (hereinafter collectively as the "Plaintiffs") against Andrew Ferrari individually and against Chair Ferrari and WVHA corporately.

In a certified notice letter dated December 23, 2014, then attorney for the Plaintiffs, Gary J. Boynton, Esq. (407-629-5300) describes the nature of the claim generally as including, but not limited to, "defamation, slander and interference with their contractual relationship." (The letter dated 12/23/14 also notices a claim against Andrew Ferrari in his individual capacity, but this firm will not represent Mr. Ferrari individually.) Attorney Boynton cites Florida Statute, §768.28(6), which provides a limited waiver of sovereign immunity on certain claims for political subdivisions of the State (such as WVHA which is a legislatively created independent special district).

Chapter 768.28(6) would limit WVHA's potential liability to Mr. McBride and/or his company to $300,000.00 as compensatory damages with no possibility of recovering punitive damages. If Attorney Boynton were to "prevail" on behalf of his clients, his attorney fee recovery is limited to 25% of the judgment or settlement amount (i.e., up to an additional $75,000.00). To the extent that the claim involves any proven allegations of actions taken "in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property", this waiver of sovereign immunity and these limits would not apply.

Attorney Tanner Andrews entered an appearance as defense counsel to represent Commissioner Ferrari individually in this lawsuit. Attorney Andrews reported that on or about June 16, 2016, Attorney Boynton filed papers in state court purporting to commence the threatened litigation on

behalf of Travis McBride as plaintiff. However, Attorney Boynton failed to serve WVHA with a summons or to pursue this filing in any way against WVHA corporately. Attorney Andrews reported that on or about December 6, 2017, Attorney Boynton filed a Suggestion of Bankruptcy on behalf of Travis McBride. Attorney Andrews reported that McBride's personal bankruptcy case resulted in discharge with the bankruptcy trustee ignoring the lawsuit as an asset, and that Central Florida Mental Health Associates filed for Chapter 7 bankruptcy protection on January 30, 2017. According to Attorney Andrews, the Chapter 7 bankruptcy trustee also decided to ignore the lawsuit as an asset. Following a discharge in the bankruptcy court, on or about August 7 2017 the circuit court granted Attorney Boynton's motion to withdraw from both representations and also granted Attorney Andrew's motion to lift the stay and restart litigation of the case. Attorney Andrews reported that Central Florida Mental Health Associates, a now bankrupt and dissolved corporation, failed to obtain substitute counsel within the 30 days allowed but that Attorney Tania Sayegh (954-368-4050) appeared timely as substitute counsel for Mr. McBride individually. Attorney Sayegh subsequently filed an Amended Complaint, stating two counts of Defamation and Harassment against Andrew Ferrari individually and two separate counts against Andrew Ferrari and WVHA corporately for Intentional Interference with a Business Relationship and Deceptive and Unfair Trade Practices. Attorney Sayegh served the Amended Complaint upon the County of Volusia, an unrelated governmental entity, but failed to serve the Amended Complaint on WVHA. Apparently unaware that her service of the Amended Complaint upon the County of Volusia was ineffective to effectuate service on WVHA, in November 2017 Attorney Sayegh moved for and obtained a Clerk's default against WVHA for failure to serve an answer. However, Attorney Sayegh subsequently moved to void the Clerk's default after Counsel made her aware of the error and the potential for WVHA moving for sanctions against her if she pursued any judgment based on a default obtained without her first effectuating proper service of process. In a motion filed contemporaneously with her motion to void the improperly obtain default, Attorney Sayegh moved to withdraw from representing Mr. McBride citing irreconcilable differences. The Court granted the consented motion to withdraw. Mr. McBride has taken no further action to pursue this action since the withdrawal of Attorney Sayegh. ***On December 9, 2018, Attorney Andrews filed a Notice of Lack of Prosecution based on the lack of any activity in the case during the 10 months preceding the Notice and thereby established a basis for the Court to dismiss the action if Mr. McBride does not show good cause.***

VII. Workers Compensation Case. [*See new info. in italics and bold*]

[Refer back to Legal Update Memorandum dated 1/7/15, 5/8/13, 11/7/12, 8/10/12, 3/10/15 and 2/10/16 for additional background details.]

Contrary to most common sense expectations, the Authority--which terminated its last employees in 2006 and sold the hospitals in 2000--remains liable on periodic "tail" treatment claims for injuries to its former hospital employees. Since 2000, these treatment claims have been processed (assessed for relationship to original injury and eligibility for payment determined) by Adventist Health System's Worker's Compensation Department ("Adventist"). Adventist has retained specialized worker's compensation counsel (Jeffrey J. Branham of the firm of Dean, Ringers, Morgan & Lawton, P.A.) to handle any of the specialized legal matters

that come up from time to time. The undersigned oversees the separately retained counsel by reviewing and giving provisional approval for Adventist to pay their bills. Of the many worker's compensation claims that were active in 2000, by 2007 only one former hospital workers continues to actively treat and submit substantial claims.

The Adventist Claims Manager, Rhonda Fletcher, who is responsible for this one remaining claim provided Counsel with an update on the current status of Adventist's periodic filings to the State's Special Disability Trust Fund ("SDTF") for reimbursement of WVHA's payments on behalf of this one remaining claimant who is 81 years old. Ms. Fletcher with counsel from Attorney Branham submitted the latest request to SDTF on September 8, 2016 seeking on behalf of WVHA reimbursement at 100% of its payments of $62,859.89 which WVHA has reimbursed to Adventists since the last request to continue treatments for this claimant. SDTF's published turnaround on such requests is 36 months, but it has generally processed payments within a year if it doesn't find any errors on the request. Counsel has notified DRT of this anticipated reimbursement so that it can be tracked appropriately on all accounting records. Ms. Fletcher notified counsel on May 4th that after much struggle and legal wrangling by Attorney Branham, SDTF has approved reimbursement to WVHA at 100% of its payments. Ms. Fletcher also noted that the subject claimant turned 82 years old and continues to receive regular treatments for pain from Dr. Khromov. DRT has received the $62,859.89 check reimbursement from SDTF. Counsel received a status update concerning the health of the remaining claimant at the end of 2018; she was at that time 83 years old, residing in a Deltona assisted living facility, and still being treated by Dr. Khromov for her chronic pain relating to the original injury date in the 1990s when WVHA still owned and operated the location of injury, West Volusia Memorial Hospital. Ms. Fletcher, with assistance of worker's compensation counsel, anticipates their submission of a new request for SDTF reimbursement in the next few months, which should once again reimburse WVHA for any expenditures on this claim.

VIII. General Compliance with the Sunshine Law:

The Government in the Sunshine Law, section 286.011, Florida Statutes, provides in pertinent part:
"All meetings of any board or commission . . . of any agency or authority of any county, municipal corporation, or political subdivision . . . at which official acts are to be taken are declared to be public meetings open to the public at all times, and no resolution, rule, or formal action shall be considered binding except as taken or made at such meeting."

It is impossible to summarize all relevant points of the Sunshine Law, but please note that courts uniformly interpret this provision as prohibiting two or more members of the same board or commission from discussing any matter on which *foreseeable* action will be taken by the pubic board or commission. (If your discussion with another board member concerns personal or business matters unrelated to the Authority, the Sunshine Law does not apply)

Please note that the Sunshine Law DOES apply to "off-the record" chats during meetings or during breaks, written correspondence, telephone conversations and e-mails exchanges between two or more board members if such communication concerns matters

likely to come before the Board. It also prohibits nonmembers (staff, lawyers, accountants, and members of the public) from serving as liaisons between Board members concerning matters likely to come before the Board.

Please note that as the Board's attorney, Counsel's role is to assist the aggregate Board with legal compliance, not to provide individualized legal opinions to a particular board member. For specific questions concerning your own compliance, please direct those inquiries to the Florida Commission on Ethics. Their website can be found at http://www.ethics.state.fl.us/ . Although their website material suggests the need for a written inquiry, each individual Board member is a "public officer" and thereby has the right to obtain informal telephone advice on common questions at (850) 488-7864.