West Volusia Hospital Authority
BOARD OF COMMISSIONERS REGULAR MEETING
March 21, 2019 5:00 p.m.
DeLand City Hall
120 S. Florida Ave., DeLand, FL

AGENDA

1. Call to Order Regular meeting
2. Opening Observance followed by a moment of silence
3. Approval of Proposed Agenda
4. Consent Agenda
    a. Approval of Minutes - Regular Meeting February 21, 2019
    b. Tentative Hearing Date Thursday September 12, 2019 @ 5:05 p.m.
    c. Tentative Final Hearing Date Thursday September 26, 2019 @ 5:05 p.m.
5. Citizens Advisory Committee (CAC), Voloria Manning, Chair
    a. CAC Applicant Workshop March 5, 2019 – Verbal Update
6. Reporting Agenda
    a. FQHC Report - Laurie Asbury, CEO, Northeast Florida Health Services, Inc. (NEFHS), d/b/a Family Health Source (FHS) February 2019 Report
    b. The House Next Door February 2019 Report, Gail Hallmon, Operations Director
7. Citizens Comments
    a. EMPros Presentation, Dr. Duva, CEO (see Legal Update attached)
        1. EMPros Letter to Attorney Small dated 2/7/2019 (attached)
        2. Excel spreadsheet 2019 Medicare Physician Fee Schedule and payment history chart back to 1999 (attached)
        3. Power Point Presentation (attached)
8. Contractual Utilization Reports to the WVHA Board of Commissioners
    a. Waylan Niece, Case Manager, The Neighborhood Center
    b. Tachara Ferguson Reid, Florida Department of Health
9. Discussion Items
    a. WVHA as Plaintiff in Federal Multidistrict Litigation for National Prescription Opiate Litigation (see Legal Update attached)
        1. Contingent Fee Retainer Agreement (attached)
    b. Approval of Management Representation Letter
    c. James Moore & Company WVHA FYE 2018 Audit Presentation- Zach Chalifour, CPA
    d. NEFHS Letter to Board dated 2/12/2019 (attached) Re: 2017-2018 Budget overage $43,349.00 and request to reinstate original funding request of $1,253,930.00 for 2018-2019
10. Follow Up Items
    a. UMR February 2019 Report- Shawn Jacobs, Strategic Account Executive, Donna Lupo, Strategic Account Executive
    b. WVHA/UMR Health Benefit Summary Plan Description (attached)
        1. Letter of Acceptance dated 2/22/2019
    c. TPA Matters
    d. UMR Check Run ending 2/7/2019 $1,355,367.39 in hospital claims identified as being greater than 90 days old and UMR Check Run ending 2/14/2019 $3,379.33 in hospital claims identified as being greater than 90 days old: Total $1,358,746.72 minus $40,697.44 in accruals remaining for FYE 2018
    e. UMR Administrative Services Agreement
11. Finance Report
    a. February Financials
12. Legal Update
13. Commissioner Comments
14. Adjournment

WEST VOLUSIA HOSPITAL AUTHORITY
WVHA BOARD OF COMMISSIONERS REGULAR MEETING

DeLand City Hall
120 S. Florida Avenue, DeLand, Florida
February 21, 2019, 2019
5:00 pm

Those in Attendance:
Commissioner Dolores Guzman
Commissioner Andy Ferrari
Commissioner John Hill

Absent:
Commissioner Kathie D. Shepard
Commissioner Judy Craig

CAC Members Present:
Voloria Manning
Lynn Hoganson

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, P.A. (DRT)
Administrative Support: Eileen Long, DRT

Call to Order Regular Meeting

Vice-Chair Guzman called the meeting to order and declared that a quorum was established with the presence of three Commissioners. 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. The meeting was opened with a moment of silence, followed by The Pledge of Allegiance.

Approval of Proposed Agenda

Motion 012- 2019 Commissioner Hill motioned to approve the amended agenda as presented. Commissioner Ferrari seconded the motion. The motion passed unanimously.

Consent Agenda

Approval of Minutes – Organizational/Regular Meeting Minutes January 17, 2019

Motion 013 - 2019 Commissioner Hill motioned to approve the Consent Agenda. Commissioner Ferrari seconded the motion. The motion passed unanimously.

Citizens Advisory Committee (CAC) Voloria Manning, Chair

CAC Meeting Minutes – Organizational February 5, 2019 (Draft)

Citizens Comments

There was one.

Reporting Agenda

UMR November/December Report –Written Submission
FQHC Report, Laurie Asbury, CEO, Northeast Florida Health Services, Inc. d/b/a Family Health Source (FHS) November/December Report
The House Next Door (THND) January HealthCard Application Report

Ms. Gail Hallmon, Operations Director, THND updated the Board on their first full month of processing and approving/denying the WVHA HealthCard applications.

Contractual Verbal Utilization Reports to the WVHA Board of Commissioners
Healthy Start Coalition of Flagler & Volusia

Ms. Dixie Morgese, Executive Director, Healthy Start Coalition of Flagler & Volusia provided their verbal utilization report and provided a Power Point Presentation (attached).

Community Life Center

Ms. Yvonne Levesque, Interim Operations Manager, Community Life Center updated the Board by explaining that they have not submitted an invoice for outreach services to the WVHA since October of 2018. This is because they are transitioning from paper files to a data base system and there were numerous matters that they needed to correct in respect to those client files. This data base system was implemented as of January 1st, 2019.

Hospital Quarterly Report
Advent Health Fish Memorial – Rob Deininger, CEO and/or Danielle Johnson, COO
Advent Health DeLand – Lorenzo Brown, CEO and/or Kyle Glass, CFO

Ms. Danielle Johnson, COO and Mr. Kyle Glass, CFO provided the Board with their respective quarterly updates, along with a Power Point Presentation (attached).

Discussion Items

Commissioner John Hill's CAC Appointees
Linda White-CAC Application attached
Brian Soukup-CAC Application attached

Motion 014 – 2019 Commissioner Hill motioned to appoint Linda White and Brian Soukup as his CAC members.

The motion died for lack of second.

Proposed Changes to Eligibility Guidelines (EG)

Mr. Small reminded the Board that this is an annual review process that will ultimately come before the Board for a vote in May.

Funding Application revisions collaboratively made by DRT & TWSPA
Primary Care Funding Application Revised 2-21-2019
Non-Primary Care Funding Application Revised 2-21-2019

Mr. Small added some language to page 3 of 10 of the Non-Primary Care Funding Application.

Motion 015 – 2019 Commissioner Ferrari motioned to approve both funding applications as revised in the packet and as amended by Attorney Small. Commissioner Hill seconded the motion. The motion passed unanimously.

Board approval to release 2019-2020 Funding Applications Tuesday, February 26, 2019

Motion 016 – 2019 Commissioner Hill motioned to release the funding applications on Tuesday, February 26, 2019. Commissioner Ferrari seconded the motion. The motion passed unanimously.

Attorney Theodore W. Small to attend CAC Applicant Workshop 3-5-2019

Motion 017 – 2019 Commissioner Ferrari motioned to authorize Attorney Small's attendance during the March 5, 2019 CAC Applicant Workshop. Commissioner Hill seconded the motion. The motion passed unanimously.

NEFHS Letter to Board dated 2-12-2019 (attached) Re: 2017-2018 Budget overage $43,349.00 and request to reinstate original funding request of $1,253,930.00 for 2018-2019

Motion 018 – 2019 Commissioner Ferrari motioned to table the NEFHS matter until the March 21, 2019 Board meeting due to two Commissioners being absent. Commissioner Hill seconded the motion. The motion passed unanimously.

Follow Up Items

TPA Matters

Mr. Cantlay addressed the Board explaining that as part of an ongoing discussion about better ways to provide services to our client population we had an opportunity to discuss the possibility of purchasing a health insurance policy for each member that aligns with the coverage provided by Medicaid Managed Care or a Medicaid HMO. This has been an idea floated around by various commissioners over the years. We are in the very early stages of determining if this is a possibility and will update the Board as to our progress at our earliest opportunity.

UMR Administrative Services Agreement

Mr. Small addressed the Board and his concerns with the agreement as presented by UMR with the potential waiver of the Board's sovereign immunity and the indemnification whereby UMR is only indemnifying the WVHA for "gross negligence".

Motion 019 – 2019 Commissioner Ferrari motioned to table the decision on the UMR Administrative Services Agreement so that all Commissioners can be present to take part in this decision. Commissioner Hill seconded the motion. The motion passed unanimously.

CRA Waiver Update
Springhill CRA expiration date December 31, 2044

Mr. Small referred to his Legal Update pages 6 and 7 (attached) and believed that the Board would receive more openness from the City of DeLand Council to consider a waiver of the extension to the Downtown DeLand CRA by 11 years, from 2025 to 2036 and not to pursue any disruption to either of the current existing Downtown DeLand CRA or the Springhill CRA.

There was Board consent to authorize Attorney Small to seek a waiver of the 11 year extension to the Downtown DeLand CRA.

Hospital Budget 2017-2018 Update Re: POMCO Refund $594,915.83

Motion 020 – 2019 Commissioner Ferrari motioned to pay the hospitals, based upon their 2017-2018 budget, the amount of $594,915.83. Commissioner Hill seconded the motion. The motion passed unanimously.

Financial Report

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

Motion 021 – 2019 Commissioner Ferrari motioned to pay bills totaling $2,319,357.69 (See attached). Commissioner Hill seconded the motion. The motion passed unanimously.

Legal Update

Mr. Theodore Small, Legal Counsel for the WVHA submitted his legal update memorandum dated February 12, 2019 (See attached).

Commissioner Comments

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

Adjournment,

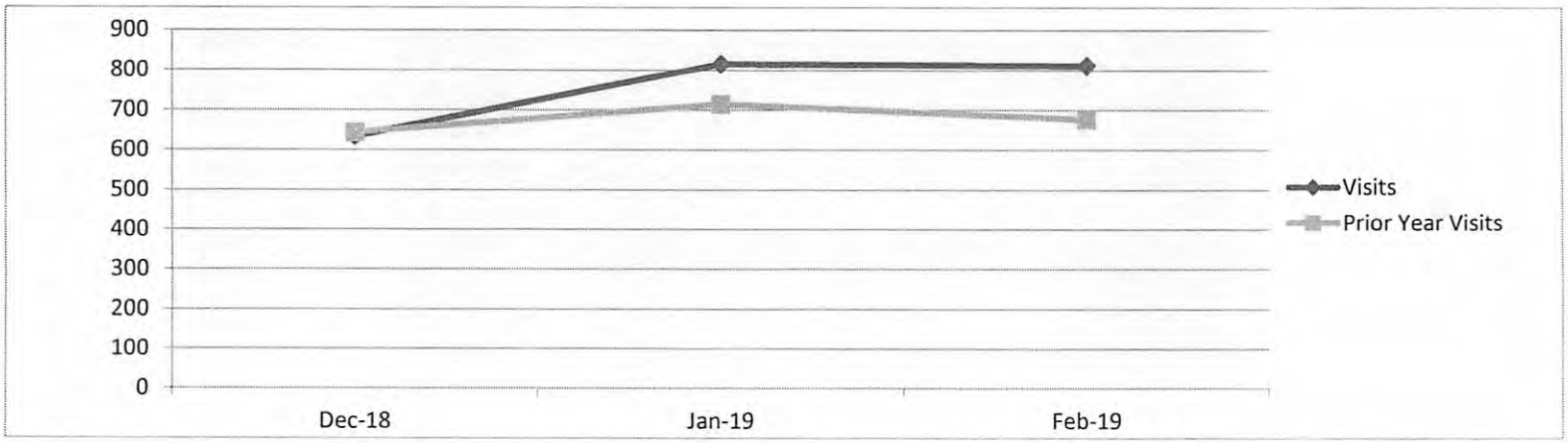
Dolores Guzman, Vice-Chair

FAMILY Health Source

Northeast Florida Health Services
February-19

Patient Visits

	Dec-18	Jan-19	Feb-19
Visits	634	815	811
Prior Year Visits	644	714	677

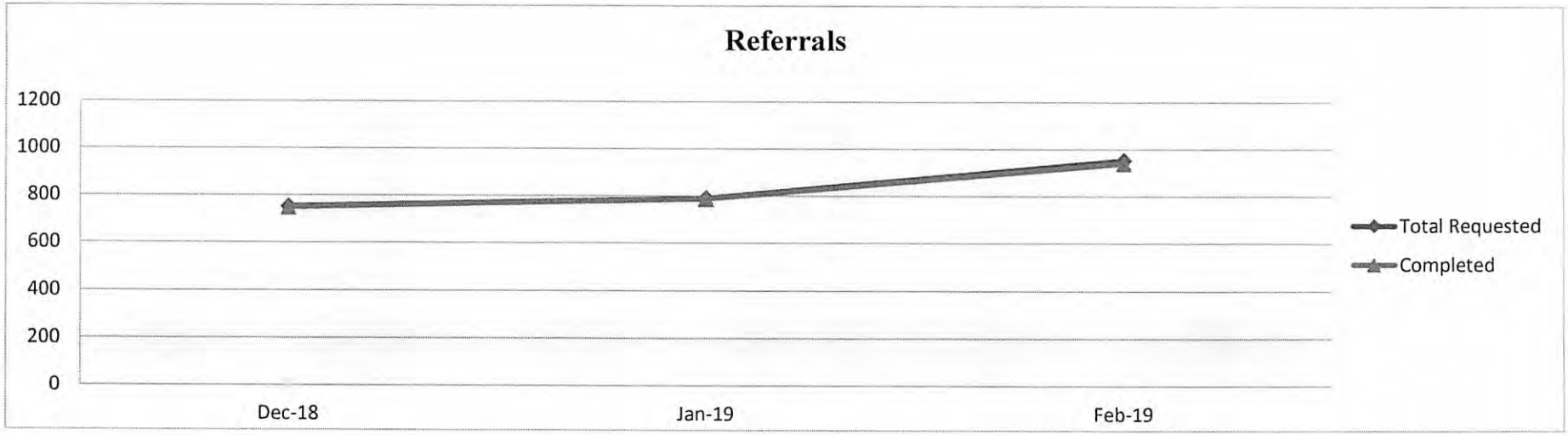


Patient Visits by Location

Location	Dec-18	Jan-19	Feb-19
Deland Medical	258	387	382
Deltona Medical	223	320	328
Pierson Medical	80	96	90
Daytona	73	12	11
Total	634	815	811

Referrals

	Dec-18	Jan-19	Feb-19
NEFHS Providers (refer to footnote 1)	233	240	138
Internal Specialty Providers (refer to footnote 2	520	550	815
Total	753	790	953
Outstanding NEFHS Providers	0	0	2
Outstanding Int. Speciality Providers	3	2	11
Completed	750	788	940
Total Requested	753	790	953



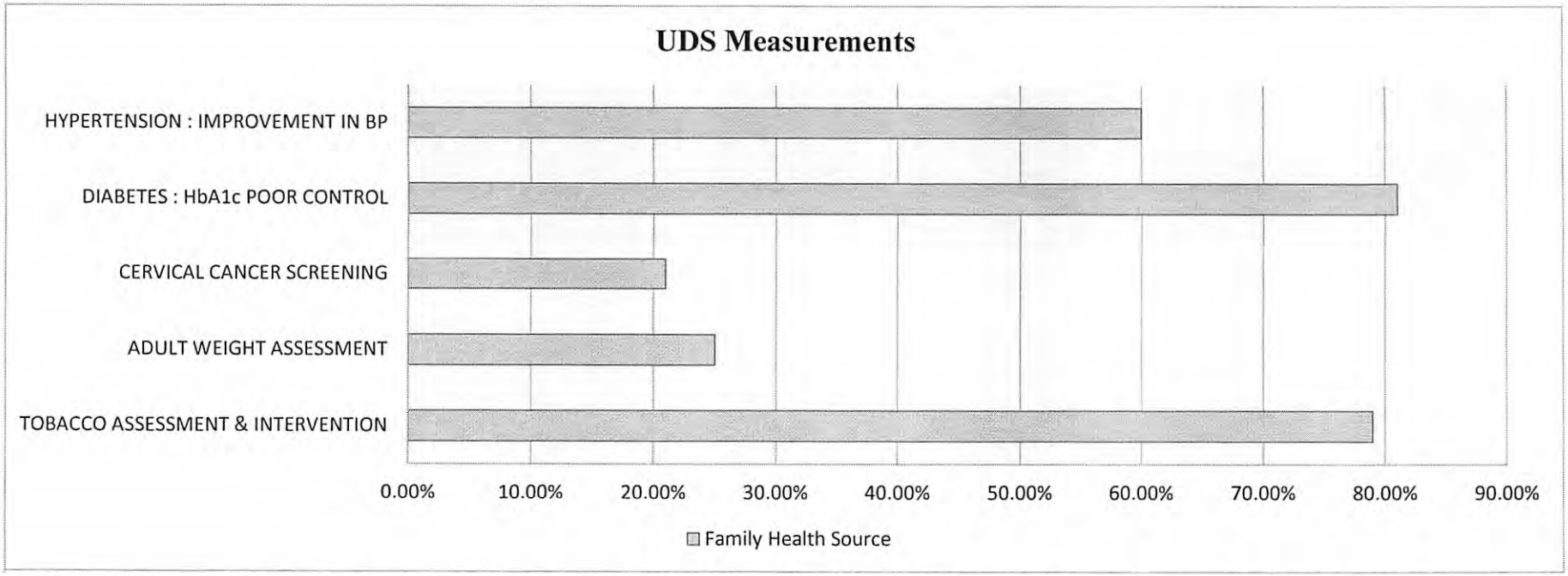
1 NEFHS provider referrals are generated by NEFHS PCP for imaging and durable medical equipment (DME).
2 Internal specialty provider referrals are generated by NEFHS PCP for consultation with a specialist.

Appointment Times

Location	Provider	Appointments
Daytona	Johnson	Same Day
Daytona	Sauls	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 February 2019	Family Health
TOBACCO ASSESSMENT & INTERVENTION	79.00%
ADULT WEIGHT ASSESSMENT	25.00%
CERVICAL CANCER SCREENING	21.00%
DIABETES : HbA1c POOR CONTROL	81.00%
HYPERTENSION : IMPROVEMENT IN BP	60.00%



Nurturing Families
Building Communities

The House Next Door
Serving
Volusia and Flagler Counties

Administrative Offices 804 North Woodland Blvd. DeLand, FL 32720
386-734-7571
386-734-0252 (fax)

DeLand Counseling Center
121 W. Pennsylvania Ave.
DeLand, FL 32720
Counseling: 386-738-9169
Programs: 386-734-2236
386-943-8823 (fax)

Deltona Counseling Center 840 Deltona Blvd., Suite K Deltona, FL 32725
Counseling and Programs:
386-860-1776
386-860-6006 (fax)

Flagler Counseling Center
25 N Old Kings Road #7B
Palm Coast, FL 32137
386-738-9169
386-943-8823

S. Daytona Counseling Center
1000 Big Tree Road Daytona Beach, FL 32114 386-301-4073
386-492-7638 (fax)

March 11, 2019

West Volusia Hospital Authority

Monthly Enrollment Report

In the month of February there were 418 appointments to assist with new applications and 108 appointments to assist with pended applications from January for a total of 526 face to face contact with clients.

310 applications were submitted for verification and enrollment. Of these, 280 were processed by the end of the month leaving the balance of 154 to roll over into March for approval.

Of the 280 that were processed, 143 were approved and 11 were denied. The remaining were pended and letters were sent out to the clients.

Currently applications are being processed, approved and the client enrolled in 17 business days. We have identified several steps to reduce the number of pended applications and to shorten the time from applying to enrollment.

Respectfully submitted by Gail Hallmon

WEST VOLUSIA HOSPITAL AUTHORITY

DeLand City Hall
120 S. Florida Avenue, DeLand, FL

TENTATIVELY SCHEDULED MEETINGS - 2019

Citizens Advisory Committee Meetings Tuesdays at 5:15pm	Joint Meetings	Board of Commissioners Meetings Thursdays at 5:00pm
February 5 - CAC Organizational/Orientation *Judy Craig		**January 17 - Organizational/Regular** **February 21 (FLA HOSP/HSCFV/Community Life Center)**
March 5 – Applicant Workshop *Andy Ferrari		**March 21 (TNC/Good Sam/FDOH) (UMR to Attend)**
	April 18 – 5 p.m. Joint meeting of WVHA Board and CAC – Preliminary Funding application review	
May 7 - Discussion/Q&A Meeting *John Hill		**May 16 (FLA HOSP-SMA/RAAO)**
May 21 - Scoring Meeting * Dolores Guzman		
	June 20 – 4 p.m. Primary Care Application Workshop (duration 1 ½ hours)	
	June 20 – 5:30 p.m. Joint meeting of WVHA Board and CAC–Funding Recommendations	
July (CAC Hiatus)		**July18 (4:00 p.m.) Budget Workshop Followed by Regular (THND/Healthy Comm) (UMR to Attend)**
August (CAC Hiatus)		**August 15 (FLA HOSP/HHI/CLSMF)**
September (CAC Hiatus)		**September 12 – Initial Budget Hearing** **September 26 - Final Budget Hearing/Regular Meeting**
October (CAC Hiatus)		**October 17**
November (CAC Hiatus)		**November 14 (FLA HOSP)**

***WVHA Commissioner to attend CAC Meeting**
Meetings to be held at DeLand City Hall Commission Chamber 120 S. Florida Avenue, DeLand FL
Meetings to be held at DRT, 1006 N. Woodland Blvd., DeLand, FL

EMPROS
emergency medicine professionals,p.a.

Dear Ted, February 7, 2019

In follow up to your request at our meeting last month, EMPros has put together some data for your review. EMPros has been providing care to indigent patients in West Volusia for the last 43 years. Over the last 20 years, EMPros has faithfully provided care to all indigent patient presenting to the Emergency Departments in West Volusia who do not qualify for any local, state, or federal funding totaling $99 million dollars in gross charges. Throughout the last 20 years, EMPros has also provided comprehensive care for those who qualify for funding through the provisions of the West Volusia Hospital Authority.

During 2017, EMPros was reimbursed approximately $40 per qualified indigent patient visit by the West Volusia Hospital Authority which includes care of patients with life and limb threatening illness and injuries. To put this in perspective, Medicare reimburses a single RVU for care of a patient at $36 and the average RVUs per qualified indigent patient visit in 2017 was approximately 4.

During 2018, EMPros was reimbursed less than $20 per qualified indigent patient visit by the West Volusia Hospital Authority. EMPros was paid a grand total of $27,300 for care of qualified indigent patients during 2018.

The West Volusia Hospital Authority budget for healthcare expenditures exceeds $17,500,000. EMPros is asking that careful consideration is given by the WVHA Board of Directors to the amount of uncompensated care we have provided over the last 40+ years and undercompensated care we have rendered for patients who qualify for funding through the West Volusia Hospital Authority over the last 20 years.

Our colleagues in other specialties have been reimbursed at rates that exceed Medicare rates for qualified indigent patients while EMPros has been paid at rates less than Medicare rates (please see attached chart). Medicare rates of reimbursement have been shown not to cover the cost of care in most markets (https://www.fiercehealthcare.com/practices/2019-medicare-payments-won-t-cover-cost-for-many-physician-practices). EMPros does not expect to receive Usual and Customary Rates for services rendered to indigent patients which would far exceed Medicare rates.

Our colleagues in other specialties may refuse to render care for patients who are uninsured or cannot afford to pay for their services. EMPros has faithfully maintained a safety net for all citizens of West Volusia, regardless of their ability to pay. Without appropriate and fair reimbursement, the safety net is threatened. Appropriate compensation to EMPros for critical services rendered by the West Volusia Hospital Authority moving forward will strengthen the safety net.

We look forward to presenting to the West Volusia Hospital Authority Board of Directors. EMPros welcomes your comments and direction as we seek to negotiate an appropriate contract for our services.

Sincerely,

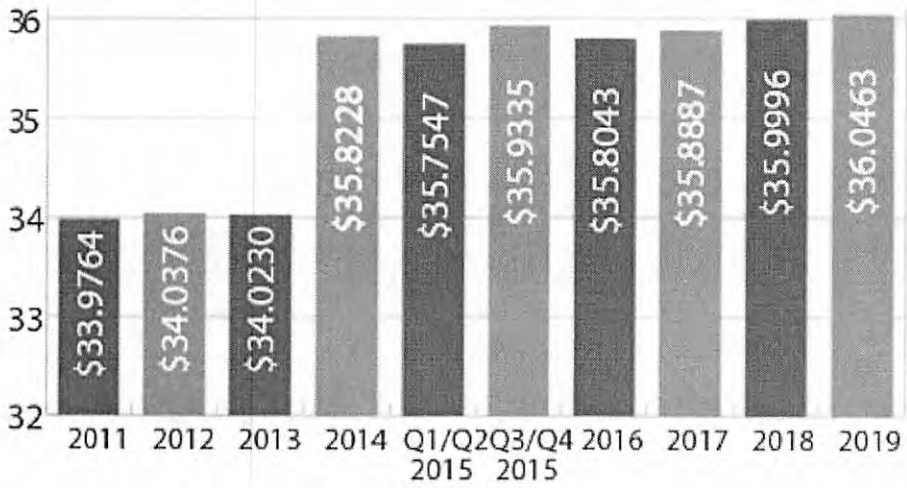
Charles Duva, MD, FACEP, CMM
C.E.O. & President

Facility Nar (Multiple Items)

Row Labels	Visit Count	Visit Total Charges	Visit Total Gross Payments	Visit Total RVU 2013	Medicare Allowable per RVU	Revenue @ Medicare Alloawable
1999	1	$80.00	$80.00	1.18	$33.00	$38.94
2000	1	$230.00	$65.00	3.36	$33.00	$110.88
2001	1	$230.00	$65.00	3.36	$33.00	$110.88
2002	1	$150.00	$58.00	1.76	$33.00	$58.08
2003	940	$213,506.00	$54,107.25	2,417.63	$33.00	$79,781.79
2004	2,176	$524,537.00	$140,626.44	6,005.96	$33.00	$198,196.68
2005	2,057	$534,271.00	$140,331.61	6,210.91	$33.00	$204,960.03
2006	2,788	$797,691.00	$155,745.87	8,848.75	$33.00	$292,008.75
2007	2,933	$970,183.00	$150,937.47	9,236.99	$33.00	$304,820.67
2008	3,113	$1,071,643.00	$185,170.61	10,245.52	$33.00	$338,102.16
2009	1,911	$702,531.00	$113,940.80	6,170.33	$33.00	$203,620.89
2010	1,893	$824,827.00	$102,929.72	6,028.28	$33.98	$204,819.25
2011	1,823	$908,162.00	$106,405.00	5,793.75	$34.04	$197,205.35
2012	2,046	$1,049,752.00	$120,445.00	6,534.27	$34.02	$222,315.47
2013	1,924	$1,083,476.00	$116,220.00	6,391.46	$35.82	$228,959.99
2014	1,392	$868,157.00	$78,268.00	4,676.48	$35.75	$167,206.14
2015	1,447	$959,149.00	$80,925.00	5,080.07	$35.93	$182,544.70
2016	1,658	$1,235,586.00	$79,661.00	6,432.59	$35.80	$230,314.38
2017	1,723	$1,435,483.00	$74,844.68	6,812.28	$35.89	$244,483.87
2018	1,446	$1,244,482.00	$27,300.00	5,735.09	$36.00	$206,460.95
2019	83	$80,986.00	$0.00	364.69	$36.05	$13,145.73
Grand Tota	**31,357**	**$14,505,112.00**	**$1,728,126.45**	**102,994.71**		$3,519,265.57

2019 Medicare Physician Fee Schedule Released

By Michael A. Granovsky, MD, FACEP, CPC, and David A. McKenzie, CAE | on December 17, 2018 | 0 Comment



MEMORANDUM

TO: WEST VOLUSIA HOSPITAL AUTHORITY

FROM: JAMES VICKARYOUS, ESQ.

SUBJECT: NATIONAL PRESCRIPTION OPIATE LITIGATION – FEDERAL MULTIDISTRICT LITIGATION

DATE: MARCH 12, 2019

CC: TED SMALL, ESQ.

The WVHA has a claim in the pending Federal Multidistrict Litigation for National Prescription Opiate Litigation.

Over the past several years governmental entities began filing state court lawsuits against opioid makers and distributors in an attempt to stop the epidemic in their communities. The lawsuits stated that the prescription opioid makers grossly misrepresented the risks of long-term use of those prescription drugs, and distributors failed to properly monitor suspicious orders of those prescription drugs, which caused the current opioid epidemic. The opioid makers removed the vast majority of the state court lawsuits into the Federal courts. The Federal court system ordered all opioid lawsuits to be consolidated into a multidistrict litigation action in the U.S. District Court for the Northern District of Ohio and assigned the cases to Judge Dan Polster.

Any lawsuit filed by the WVHA would be litigated in Ohio's Northern District Court in Cleveland, Ohio. There are many articles on the topic, but the most illustrative showing the intent of the judge was published by the New York Times. In December 2018 Judge Polster entered an order denying the defendants' motion to dismiss, stating that the various municipalities and governmental entities may proceed with their lawsuits. Judge Polster made the following observation in his order: "It is accurate to describe the opioid epidemic as a man-made plague, twenty years in the making. The pain, death, and heartache it has wrought cannot be overstated."

The WVHA may claim for the reimbursement of expenses spent over the past two decades, current expenditures, and expenditures for future remediation of this public nuisance (among other categories of damages). Time is of the essence, as the judge is pushing the parties to resolve the cases sooner rather than later (three "bellwether" trials have been set for October 2019).

ATTORNEY JIM VICKARYOUS PROFESSIONAL BIOGRAPHY

Jim Vickaryous is a member of the Florida Bar Board of Governors, representing 2,200 lawyers in Seminole and Brevard Counties (Florida's 18th Judicial Circuit). Jim's 25 year legal career has enabled him to represent thousands of clients in courts across Florida and the United States in significant injury cases. Jim is a civil trial lawyer and the managing partner at Vickaryous Law Firm in Seminole County, Florida.

Jim was born into an Alaskan pioneer farming family and moved to Florida as a boy. Seeing a budding warrior, the U.S. Army awarded Jim a full scholarship to attend the University of Miami for his undergraduate degree. Jim attended Florida's premier courtroom advocacy training institution, Stetson University College of Law, for both his law degree and MBA. Jim lost his first law firm after being activated by the US Army and mobilized with his military police reserve unit to keep the peace between Serbians and European Muslims in Bosnia. Despite receiving the NATO Medal for Service in Former Yugoslavia and the prestigious Army Meritorious Service Medal, Jim is most proud of bringing his troops home to their families unharmed. Jim started a new law firm after coming back from being deployed to Bosnia and receiving an honorable discharge from the U.S. Army Reserves.

Jim has obtained many millions of dollars in compensation for his clients over decades of representing people in Florida courtrooms. Jim is recognized as having the highest jury verdict in Seminole County, Florida for a head injury causing a debilitating migraine. Jim's services are sought out by international clients, with many clients being referred to the Vickaryous Law Firm by large British law firms. Jim represented over a hundred plaintiffs in the Florida Engle Trust Fund tobacco settlement. Florida Trend magazine has named Jim to its 2019 Legal Elite status and was elected by his peers as a 2019 Super Lawyer. Jim is rated AV by Martindale Hubble (the highest rating available).

Jim's peers in the legal community have sought him out for leadership as the 2015 Seminole County Bar Association president and the 2017 Central Florida Trial Lawyers Association president. Jim was instrumental in obtaining the 2018 charter for the Seminole County Florida Association for Women Lawyer's chapter, the county's only woman's legal professional organization. Jim has built one the most successful law firms in Seminole County and believes in giving back to the communities that have helped his law practice in so many ways. Jim is a lifetime fellow of the Florida Bar Foundation and a member of the Brevard Bar Foundation. Jim is passionate about helping the homeless get back on their feet, serving for over a half a decade as the Chairman of the Rescue Outreach Mission, Seminole County's only homeless shelter serving the needs of homeless women, children and men. Jim is the humble recipient of the Brevard Bar Foundation's 2019 Community Leader of the Year Award. Jim has been happily married to Jennifer Ferguson for two decades and they have three children: Stacy (a twenty something missionary in Manhattan), Evan (a teenage budding football and baseball player), and Irelyn (a grade schooler who loves the arts).

CONTINGENT FEE RETAINER AGREEMENT

WEST VOLUSIA HOSPITAL AUTHORITY DISTRICT

This Contingent Fee Retainer Agreement ("Agreement"), is made this _____ day of _____, 2019, by and between WEST VOLUSIA HOSPITAL AUTHORITY ("District") and MICHAEL KAHN, P.A.; ROMANO LAW GROUP; SCHOCHOR, FEDERICO and STATON, P.A.; SPANGENBERG, SHIBLEY & LIBER, LLP; DOUGLAS R. BEAM P.A.; and JAMES G. VICKARYOUS, P.A. ("Retained Counsel").

WHEREAS, the Retained Counsel proposed to represent the District in connection with claims for damages ("Claims") arising out of the manufacture, distribution, and sale of opioid drugs ("Opioids") against companies that manufacture Opioids ("Manufacturers"), companies that distribute) Opioids ("Distributors") and other defendants; and

WHEREAS, the District has agreed to retain the Retained Counsel in accordance with the terms of this Agreement.

NOW, THEREFORE, this Agreement provides as follows:

1. The District hereby retains the Retained Counsel to represent the District in connection with the Claims.

2. The Retained Counsel will provide such legal services as may be required in order to bring about a resolution of the Claims. Such services may include *inter alia*: investigating the merits of the Claims; drafting and filing a Complaint; handling all pre-trial, discovery, and motion proceedings; retaining expert witnesses; trying the case; and briefing and arguing any appeal. It is the Retained Counsel's intention to pursue these Claims in federal court in the Multi District Litigation in the Northern District of Ohio.

3. The Retained Counsel will advance the full cost of any expenses necessary or

required to be incurred in connection with this matter, without contribution from the District except as set forth herein.

4. Payment of a contingent legal fee ("Contingent Fee") and reimbursement of all expenses incurred on behalf of the District and paid by the Retained Counsel shall be the District's sole obligation to compensate the Retained Counsel in this matter, except as indicated in paragraph 7.

5. The Contingent Fee shall be payable by the District to the Retained Counsel in accordance with the following schedule:

a. Ten percent (10%) of the gross amount recovered if the Claims are settled prior to filing a Complaint.

b. Twenty percent (20%) of the gross amount recovered if the Claims are settled prior to the first day of trial.

c. Twenty-two and a half percent (22.5%) of the gross amount recovered after a trial on the merits.

d. Twenty-five percent (25%) of the gross amount recovered after any post-judgment appeal, regardless of whether the appeal is brought by or against the District.

In no event will the contingent fee payable to the Retained Counsel exceed that which is permissible under the Florida Bar rules.

The payment of fees as outlined above is entirely contingent upon the Retained Counsel recovering money for the District. If the Retained Counsel makes no recovery for the District, then

the District will not be responsible for paying any fee to the Retained Counsel.

6. In addition to the Contingent Fee payable pursuant to paragraph 5 of this Agreement, the District shall reimburse the Retained Counsel out of the gross amount recovered the full amount of all expenses incurred on behalf of the District and paid by the Retained Counsel in connection with this matter. The District is not responsible for advancing any costs for this litigation. If the Retained Counsel does not make any recovery for the District then the District will not be responsible for reimbursing the Retained Counsel for any costs incurred by the Retained Counsel in prosecuting this case.

7. In the event the District terminates this Agreement prior to any recovery on account of the Claims and subsequently recovers any amount on account of such Claims, the District agrees to compensate the Retained Counsel for those fees permitted under Florida law and reimburse the expenses the Retained Counsel incurred on behalf of the District in accordance with the terms of paragraph 6 of this Agreement.

8. This Agreement shall be governed by and construed in accordance with the laws of the State of Florida with venue for any dispute arising hereunder lying in Brevard County, Florida.

9. It is expressly agreed that this Agreement represents the entire agreement between the District and the Retained Counsel, that all provisions and understandings between the parties are merged in this Agreement, and that no modification of this Agreement shall be valid except by a writing signed by all parties.

10. In the event that the court or arbitrator requires another party to the litigation (or its counsel) to pay attorneys' fees and/or costs to the District and/or the Retained Counsel, such award

will not affect the amount the District is obligated to pay the Retained Counsel under this Agreement. If such award is less than the amount that the District is obligated to pay the Retained Counsel under this Agreement, then such award will be credited toward the total amount owed under this Agreement, and the District will be responsible for paying the balance to the Retained Counsel out of the gross recovery. If such award is greater than the amount the District is obligated to pay the Retained Counsel under this agreement, then the Retained Counsel will be entitled to the amount awarded by the court or arbitrator, and the District will not owe the Retained Counsel any fee.

On behalf of West Volusia Hospital District, I have, before signing this contract, received and read the Statement of Client's Rights, and understand each of the rights set forth therein. I have signed the statement and received a signed copy to keep for reference while being represented by the Retained Counsel. This contract may be cancelled by written notification to the Retained Counsel at any time within three (3) business days of the date the contract was signed, as first above written, and if cancelled, the District shall not be obligated to pay any fees to the Retained Counsel for the work performed during that time. If the Retained Counsel has advanced funds to others in pursuing this case, the Retained Counsel is entitled to be reimbursed for such amounts as it has reasonably advanced on the District's behalf. The District acknowledges, understands, and agrees to all the terms of this agreement.

WEST VOLUSIA HOSPITAL
AUTHORITY DISTRICT

By: _____
Name:_____

Title: _____

IN WITNESS WHEREOF, the hands and seals of the parties hereto as of the day and year first above written.

WEST VOLUSIA HOSPITAL
AUTHORITY DISTRICT

By: _____
Name:_____

Title: _____

MICHAEL KAHN, P.A.

By: _____
Michael Kahn, Esq.
President

SCHOCHOR, FEDERICO AND STATON, P.A.

By: _____
Name

_____
Title

SPANGENBERG, SHIBLEY & LIBER, LLP

By: _____
Name

_____
Title

DOUGLAS R. BEAM P.A.

By: _____
Name

_____
Title

JAMES G. VICKARYOUS, P.A.

By: _____
Name

_____
Title

STATEMENT OF CLIENT'S RIGHTS

Before you, the prospective client, arrange a contingency fee agreement with a lawyer, you should understand this Statement of your rights as a client. This Statement is not a part of the actual contract between you and your lawyer, but as a prospective client you should be aware of these rights:

1. There is no legal requirement that a lawyer charge a client a set fee or a percentage of money recovered in a case. You, the client, have the right to talk with your lawyer about the proposed fee and to bargain about the rate or percentage as in any other contract. If you do not reach an agreement with one lawyer, you may talk with other lawyers.

2. Any contingency fee contract must be in writing and you have three (3) business days to reconsider the contract. You may cancel the contract without any reason if you notify your lawyer in writing within three (3) business days of signing the contract. If you withdraw from the contract within the first three (3) business days, you do not owe the lawyer a fee, although you may be responsible for the lawyers actual costs during that time. If your lawyer begins to represent you, your lawyer may not withdraw from the case without giving you notice, delivering necessary papers to you, and allowing you time to employ another lawyer. Often, your lawyer must obtain court approval before withdrawing from a case. If you discharge your lawyer without good cause after the three (3) day period, you may have to pay a fee for work the lawyer has done.

3. Before hiring a lawyer, you, the client, have the right to know about the lawyer's education, training and experience. If you ask, the lawyer should tell you specifically about his or her actual experience dealing with cases similar to yours. If you ask, the lawyer should provide information about special training or knowledge and give you this information in writing if you request it.

4. Before signing a contingency fee contract with you, a lawyer must advise you whether he or she intends to handle your case alone or whether other lawyers will be helping with the case. If your lawyer intends to refer the case to other lawyers, he or she should tell you what kind of fee sharing arrangement will be made with the other lawyers. If lawyers from different law firms will represent you, at least one lawyer from each law firm must sign the contingency fee contract.

5. If your lawyer intends to refer your case to another lawyer or counsel with other lawyers, your lawyer should tell you about that at the beginning. If your lawyer takes the case and later decides to refer it to another lawyer or to associate with other lawyers, you should sign a new contract which includes the new lawyers. You, the client, also have the right to consult with each lawyer working on your case and each lawyer is legally responsible to represent your interests and is legally responsible for the acts of the other lawyers involved in the case.

6. You, the client, have the right to know in advance how you will need to pay the expenses and the legal fees at the end of the case. If you pay a deposit in advance for costs, you may ask reasonable questions about how the money will be or has been spent and how much of it remains unspent. Your lawyer should give a reasonable estimate about future necessary costs. If your lawyer agrees to lend or advance you money to prepare or research the case, you have the right to know periodically how much money your lawyer has spent on your behalf. You also have the right to decide, after consulting with your lawyer, how much money is to be spent to prepare a case. If you pay the expenses, you have the right to decide how much to spend. Your lawyer should also inform you whether the fee will be based on the gross amount recovered or on the amount recovered minus the costs.

7. You, the client, have the right to be told by your lawyer about possible adverse consequences if you lose the case. Those adverse consequences might include money which you might have to pay to your lawyer for costs and liability you might have for attorney's fees to the other side.

8. You, the client, have the right to receive and approve a closing statement at the end of the case before you pay any money. The statement must list all of the financial details of the entire case, including the amount recovered, all expenses, and a precise statement of your lawyer's fee. Until you approve the closing statement, you need not pay any money to anyone, including your lawyer. You also have the right to have every lawyer or law firm working on your case sign this closing statement.

9. You, the client, have the right to ask your lawyer at reasonable intervals how the case is progressing and to have these questions answered to the best of your lawyer's ability.

10. You, the client, have the right to make the final decision regarding settlement of a case. Your lawyer must notify you of all offers of settlement before and after the trial. Offers during the trial must be immediately communicated and you should consult with your lawyer regarding whether to accept a settlement. However, you must make the final decision to accept or reject a settlement.

11. If at any time you, the client, believe that your lawyer has charged an excessive or illegal fee, you, the client, have the right to report the matter to The Florida Bar, the agency that oversees the practice and behavior of all lawyers in Florida. For information on how to reach The Florida Bar, call 1-850-561-5600, or contact the local bar association. Any disagreement between

you and your lawyer about a fee can be taken to court and you may wish to hire another lawyer to help you resolve this disagreement. Usually fee disputes must be handled in a separate lawsuit.

WEST VOLUSIA HOSPITAL
AUTHORITY DISTRICT

By: _____
Name:_____

Title: _____

MICHAEL KAHN, P.A.

By: _____
Michael Kahn, Esq.
President

SCHOCHOR, FEDERICO AND STATON, P.A.

By: _____
Name

_____
Title

SPANGENBERG, SHIBLEY & LIBER

By: _____
Name

_____
Title

DOUGLAS R. BEAM P.A.

By: _____
Name

_____
Title

JAMES G. VICKARYOUS, P.A.

By: _____
Name

_____
Title

Eileen Long

From: Ted Small <tsmall@businessemploymentlawyer.com>
Sent: Tuesday, March 12, 2019 2:28 PM
To: Eileen Long
Cc: Ron Cantlay
Subject: FW: Opioids - West Volusia Hospital Authority
Attachments: Contingent Fee Retainer Agreement (West Volusia Hospital Authority).pdf

I haven't had a chance to review, but please include in Board packet for discussion purposes

From: Michael Kahn [mailto:michael@michaelkahnpa.com]
Sent: Tuesday, March 12, 2019 2:17 PM
To: tsmall@businessemploymentlawyer.com
Cc: Jim Vickaryous (jim@vickaryous.com) <jim@vickaryous.com>; Roma Molinaro <roma@michaelkahnpa.com>; Melissa Tait <Melissa@michaelkahnpa.com>
Subject: FW: Opioids - West Volusia Hospital Authority

Mr. Small:

Please find attached a proposed fee agreement between our group and the West Volusia Hospital Authority. Please review and direct any questions to me. I will be glad to answer them. Our group would be privileged to represent the District. Please advise of the next step in the process.

I have copied our local counsel and group member, Jim Vickaryous on this email.

Regards, Michael Kahn

Michael H. Kahn, Esq.

michael@michaelkahnpa.com

Michael Kahn, P.A.
482 N. Harbor City Blvd.
Melbourne, FL 32935
321-242-2564
www.michaelkahnpa.com

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

March 21, 2019

West Volusia Hospital Authority
Board of Commissioners
1006 N. Woodland Blvd.
PO Box 940
DeLand, FL 32721

This representation letter is provided in connection with your audit of the financial statements of West Volusia Hospital Authority (the Authority) as of September 30, 2018 and for the year then ended, and the related notes to the financial statements, for the purpose of expressing an opinion on whether the basic financial statements present fairly, in all material respects, the financial position, results of operations, and cash flows, where applicable, of the Authority in accordance with accounting principles generally accepted for governments in the United States of America (U.S. GAAP).

Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of March 21, 2019:

Financial Statements

1. The financial statements were prepared in accordance with U.S. GAAP.
2. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.
3. We acknowledge our responsibility for the design, implementation, and maintenance of internal control to prevent and detect fraud.
4. We acknowledge our responsibility for compliance with the laws, regulations, and provisions of contracts and grant agreements applicable to us.
5. We have reviewed, approved, and taken responsibility for the financial statements and related notes.
6. We have a process to track the status of audit findings and recommendations.
7. We have identified and communicated to you all previous audits, attestation engagements, and other studies related to the audit objectives and whether related recommendations have been implemented.
8. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.
9. There have been no related party transactions.
10. All events subsequent to the date of the financial statements and for which U.S. GAAP requires adjustment or disclosure have been adjusted or disclosed.

11. There is no summary of unrecorded misstatements shown in an attached schedule since all adjustments proposed by the auditor, material and immaterial, have been recorded.
12. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.
13. All funds and activities are properly classified.
14. All funds that meet the quantitative criteria in GASB Statement No. 34, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments*, GASB Statement No. 37, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments: Omnibus* as amended, and GASB Statement No. 65, *Items Previously Reported as Assets and Liabilities*, for presentation as major are identified and presented as such and all other funds that are presented as major are considered important to financial statement users.
15. All components of net position, nonspendable fund balance, and restricted, committed, assigned, and unassigned fund balance are properly classified and, if applicable, approved.
16. The policy regarding whether to first apply restricted or unrestricted resources when an expense is incurred for purposes for which both restricted and unrestricted net position/fund balance are available is appropriately disclosed and net position/fund balance is properly recognized under the policy.
17. All expenses have been properly classified in or allocated to functions and programs in the statement of activities, and allocations, if any, have been made on a reasonable basis.
18. All interfund and intra-entity transactions and balances, if any, have been properly classified and reported.
19. Special items and extraordinary items have been properly classified and reported.
20. Deposit and investment risks have been properly and fully disclosed.
21. Capital assets, including infrastructure assets, are properly capitalized, reported, and if applicable, depreciated.
22. All required supplementary information is measured and presented within the prescribed guidelines.
23. Accrued workers' compensation claims have been properly reserved for and the amount recorded is adequate given the circumstances.
24. With regard to investments and other instruments reported at fair value:
    - The underlying assumptions are reasonable and they appropriately reflect the Authority's intent and ability to carry out its stated courses of action.
    - The measurement methods and related assumptions used in determining fair value are appropriate in the circumstances and have been consistently applied.
    - The disclosures related to fair values are complete, adequate, and in accordance with U.S. GAAP.
    - There are no subsequent events that require adjustments to the fair value measurements and disclosures included in the financial statements.

Information Provided

25. We have provided you with:
    - Access to all information, of which we are aware that is relevant to the preparation and fair presentation of the financial statements of the Authority referred to above, such as records, documentation, meeting minutes, and other matters;
    - Additional information that you have requested from us for the purpose of the audit; and
    - Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.
26. All transactions have been recorded in the accounting records and are reflected in the financial statements.
27. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
28. We have no knowledge of any fraud or suspected fraud that affects the entity and involves:

- The Board of Commissioners of the West Volusia Hospital Authority
- Employees (if any, whether current or former), contractors, and/or others who have significant roles in internal control; or
- Others where the fraud could have a material effect on the financial statements.

29. We have no knowledge of any allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, vendors, regulators, or others.
30. Except as disclosed to you, we are not aware of any pending or threatened litigation and claims whose effects should be considered when preparing the financial statements.
31. We have disclosed to you the identity of the entity's related parties. There have been no related party transactions.
32. There have been no communications from regulatory agencies concerning noncompliance with or deficiencies in accounting, internal control, or financial reporting practices.
33. The Authority has no plans or intentions that may materially affect the carrying value or classification of assets and liabilities.
34. We have disclosed to you all guarantees, whether written or oral, under which the Authority is contingently liable.
35. We have disclosed to you all significant estimates and material concentrations known to us that are required to be disclosed in accordance with GASB Statement No. 62 (GASB-62), *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*. Significant estimates are estimates at the balance sheet date that could change materially within the next year. Concentrations refer to volumes of business, revenues, available sources of supply, or markets or geographic areas for which events could occur that would significantly disrupt normal finances within the next year.
36. We have identified and disclosed to you the laws, regulations, and provisions of contracts and grant agreements that could have a direct and material effect on financial statement amounts, including legal and contractual provisions for reporting specific activities in separate funds.
37. Except as disclosed to you, we have no knowledge of:
    - Violations or possible violations of laws or regulations, or provisions of contracts or grant agreements whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency, including applicable budget laws and regulations.
    - Unasserted claims or assessments that our lawyer has advised are probable of assertion and must be disclosed in accordance with GASB-62.
    - Other liabilities or gain or loss contingencies that are required to be accrued or disclosed by GASB-62.
38. The Authority has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset or future revenue been pledged as collateral, except as disclosed to you.
39. We have complied with all aspects of grant agreements and other contractual agreements that would have a material effect on the financial statements in the event of noncompliance.
40. In order to provide oversight of the financial statement preparation services at an appropriate level, we have established effective review policies and procedures including the performance of the following functions:
    - Reconcile general ledger amounts to the draft financial statements utilizing grouping schedules to be provided by JMCO.
    - Review all supporting documentation and explanations for journal entries proposed and approve the entries.
    - Review the adequacy of financial statement disclosures by completing a disclosure checklist.
    - Review and approve schedules and calculations supporting amounts included in the notes to the financial statements.
    - Apply analytic procedures to the draft financial statements.
    - Perform other procedures as considered necessary by us.

Section 218.415, Florida Statutes, *Local Government Investment Policies*

We confirm, to the best of our knowledge and belief, the following representations made to you during your examination engagement:

41. We are responsible for complying with Section 218.415, Florida Statutes, *Local Government Investment Policies*.
42. We are responsible for selecting the criteria and have selected the following: Section 218.415, Florida Statutes, *Local Government Investment Policies*.
43. We have determined that the criteria are suitable and appropriate for our purposes.
44. We are responsible for establishing and maintaining effective internal control over compliance.
45. We assert that the Authority is in compliance with Section 218.415, Florida Statutes, *Local Government Investment Policies* for the year ended September 30, 2017.
46. There is no known noncompliance.
47. There has been no correspondence or other communications we have received from regulatory authorities, internal auditors, and other practitioners regarding possible noncompliance with the specified requirements.
48. We have made available to you all records and documentation applicable to compliance with the specified requirements.
49. There is no known noncompliance that has occurred subsequent to through the date of this letter that would affect the presentation of the Section 218.415, Florida Statutes, *Local Government Investment Policies*, or your report.
50. We represent that your report will be available for general use.

Dreggors, Rigsby & Teal, P.A.

West Volusia Hospital Authority

March 21, 2019

James Moore & Co., P.L.
121 Executive Circle
Daytona Beach, Florida 32114

This representation letter is provided in connection with your audit of the financial statements of West Volusia Hospital Authority (the Authority) as of September 30, 2018 and for the years then ended, and the related notes to the financial statements, for the purpose of expressing an opinion on whether the basic financial statements present fairly, in all material respects, the financial position, results of operations, and cash flows, where applicable, of the Authority in accordance with accounting principles generally accepted for governments in the United States of America (U.S. GAAP).

Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of March 21, 2019:

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated April 10, 2018, for the preparation and fair presentation of the financial statements of the Authority referred to above in accordance with U.S. GAAP.
2. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.
3. We acknowledge our responsibility for the design, implementation, and maintenance of internal control to prevent and detect fraud.
4. We acknowledge our responsibility for compliance with the laws, regulations, and provisions of contracts and grant agreements applicable to us.
5. We have reviewed, approved, and taken responsibility for the financial statements and related notes.
6. We have a process to track the status of audit findings and recommendations.
7. We have identified and communicated to you all previous audits, attestation engagements, and other studies related to the audit objectives and whether related recommendations have been implemented.
8. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.
9. There have been no related party transactions.
10. All events subsequent to the date of the financial statements and for which U.S. GAAP requires adjustment or disclosure have been adjusted or disclosed.
11. There is no summary of unrecorded misstatements shown in an attached schedule since all adjustments proposed by the auditor, material and immaterial, have been recorded.
12. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.
13. All funds and activities are properly classified.
14. All funds that meet the quantitative criteria in GASB Statement No. 34, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments*,

GASB Statement No. 37, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments: Omnibus* as amended, and GASB Statement No. 65, *Items Previously Reported as Assets and Liabilities*, for presentation as major are identified and presented as such and all other funds that are presented as major are considered important to financial statement users.

15. All components of net position, nonspendable fund balance, and restricted, committed, assigned, and unassigned fund balance are properly classified and, if applicable, approved.
16. Our policy regarding whether to first apply restricted or unrestricted resources when an expense is incurred for purposes for which both restricted and unrestricted net position/fund balance are available is appropriately disclosed and net position/fund balance is properly recognized under the policy.
17. All expenses have been properly classified in or allocated to functions and programs in the statement of activities, and allocations, if any, have been made on a reasonable basis.
18. All interfund and intra-entity transactions and balances, if any, have been properly classified and reported.
19. Special items and extraordinary items have been properly classified and reported.
20. Deposit and investment risks have been properly and fully disclosed.
21. Capital assets, including infrastructure assets, are properly capitalized, reported, and if applicable, depreciated.
22. All required supplementary information is measured and presented within the prescribed guidelines.
23. Accrued workers' compensation claims have been properly reserved for and the amount recorded is adequate given the circumstances.
24. With regard to investments and other instruments reported at fair value:
    - The underlying assumptions are reasonable and they appropriately reflect the Authority's intent and ability to carry out its stated courses of action.
    - The measurement methods and related assumptions used in determining fair value are appropriate in the circumstances and have been consistently applied.
    - The disclosures related to fair values are complete, adequate, and in accordance with U.S. GAAP.
    - There are no subsequent events that require adjustments to the fair value measurements and disclosures included in the financial statements.

Information Provided

25. We have provided you with:
    - Access to all information, of which we are aware that is relevant to the preparation and fair presentation of the financial statements of the Authority referred to above, such as records, documentation, meeting minutes, and other matters;
    - Additional information that you have requested from us for the purpose of the audit; and
    - Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.
26. All transactions have been recorded in the accounting records and are reflected in the financial statements.
27. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
28. We have no knowledge of any fraud or suspected fraud that affects the entity and involves:
    - The Board of Commissioners of the West Volusia Hospital Authority
    - Employees (if any, whether current or former), contractors, and/or others who have significant roles in internal control; or
    - Others where the fraud could have a material effect on the financial statements.

29. We have no knowledge of any allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees (if any, whether current or former), vendors, regulators, or others.
30. Except as disclosed to you, we are not aware of any pending or threatened litigation and claims whose effects should be considered when preparing the financial statements.
31. We have disclosed to you the identity of the entity's related parties. There have been no related party transactions.
32. There have been no communications from regulatory agencies concerning noncompliance with or deficiencies in accounting, internal control, or financial reporting practices.
33. The Authority has no plans or intentions that may materially affect the carrying value or classification of assets and liabilities.
34. We have disclosed to you all guarantees, whether written or oral, under which the Authority is contingently liable.
35. We have disclosed to you all significant estimates and material concentrations known to us that are required to be disclosed in accordance with GASB Statement No. 62 (GASB-62), *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*. Significant estimates are estimates at the balance sheet date that could change materially within the next year. Concentrations refer to volumes of business, revenues, available sources of supply, or markets or geographic areas for which events could occur that would significantly disrupt normal finances within the next year.
36. We have identified and disclosed to you the laws, regulations, and provisions of contracts and grant agreements that could have a direct and material effect on financial statement amounts, including legal and contractual provisions for reporting specific activities in separate funds.
37. Except as disclosed to you, we have no knowledge of:
    - Violations or possible violations of laws or regulations, or provisions of contracts or grant agreements whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency, including applicable budget laws and regulations.
    - Unasserted claims or assessments that our lawyer has advised are probable of assertion and must be disclosed in accordance with GASB-62.
    - Other liabilities or gain or loss contingencies that are required to be accrued or disclosed by GASB-62.
38. The Authority has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset or future revenue been pledged as collateral, except as disclosed to you.
39. We have complied with all aspects of grant agreements and other contractual agreements that would have a material effect on the financial statements in the event of noncompliance.
40. In order to provide oversight of the financial statement preparation services at an appropriate level, we have established effective review policies and procedures including the performance of the following functions:
    - Reconcile general ledger amounts to the draft financial statements utilizing grouping schedules to be provided by you.
    - Review all supporting documentation and explanations for journal entries you proposed and approve the entries.
    - Review the adequacy of financial statement disclosures by completing a disclosure checklist.
    - Review and approve schedules and calculations supporting amounts included in the notes to the financial statements.
    - Apply analytic procedures to the draft financial statements.
    - Perform other procedures as considered necessary by us.
41. In regards to the financial statement preparation assistance services performed by you, we have:
    - Made all management decisions and performed all management functions.
    - Designated a management-level individual (Ronald Cantlay, Dreggors, Rigsby, & Teal) with suitable skill, knowledge, or experience to oversee the services.
    - Evaluated the adequacy and results of the services performed.

- Accepted responsibility for the results of the services.
- Established and maintained internal controls, including monitoring ongoing activities.

Section 218.415, Florida Statutes, *Local Government Investment Policies*

We confirm, to the best of our knowledge and belief, the following representations made to you during your examination engagement:

42. We are responsible for complying with Section 218.415, Florida Statutes, *Local Government Investment Policies*.
43. We are responsible for selecting the criteria and have selected the following: Section 218.415, Florida Statutes, *Local Government Investment Policies*.
44. We have determined that the criteria are suitable and appropriate for our purposes.
45. We are responsible for establishing and maintaining effective internal control over compliance.
46. We assert that the Authority is in compliance with Section 218.415, Florida Statutes, *Local Government Investment Policies* for the year ended September 30, 2018.
47. We have communicated and disclosed to you all known noncompliance.
48. We have communicated and disclosed to you all correspondence or other communications we have received from regulatory authorities, internal auditors, and other practitioners regarding possible noncompliance with the specified requirements.
49. We have made available to you all records and documentation applicable to compliance with the specified requirements.
50. To the best of our knowledge and belief, we have disclosed to you all known noncompliance that has occurred subsequent to through the date of this letter that would affect the presentation of the Section 218.415, Florida Statutes, *Local Government Investment Policies*, or your report.
51. We represent that your report will be available for general use.

Signed:_____

Judy Craig, Chair, Board of Commissioners

Signed:_____

Ronald Cantlay, Partner, Dreggors, Rigsby & Teal

James Moore
Certified Public Accountants and Consultants

March 21, 2019

To the Board of Commissioners,
West Volusia Hospital Authority:

We have audited the financial statements of West Volusia Hospital Authority (the Authority) as of and for the year ended September 30, 2018, and have issued our report thereon dated March 21, 2019. Professional standards require that we advise you of the following matters relating to our audit.

Our Responsibility in Relation to the Financial Statement Audit

As communicated in our engagement letter dated April 10, 2018, our responsibility, as described by professional standards, is to form and express an opinion about whether the financial statements that have been prepared by management with your oversight are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of its respective responsibilities.

Our responsibility, as prescribed by professional standards, is to plan and perform our audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement. An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control over financial reporting. Accordingly, as part of our audit, we considered the internal control of the Authority solely for the purpose of determining our audit procedures and not to provide any assurance concerning such internal control.

We are also responsible for communicating significant matters related to the audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

We have provided our comments regarding our recommendations during our audit, if any, in a separate report to you dated March 21, 2019.

Planned Scope and Timing of the Audit

We conducted our audit consistent with the planned scope and timing we previously communicated to you.

Compliance with All Ethics Requirements Regarding Independence

The engagement team, other individuals in our firm, and our firm have complied with all relevant ethical requirements regarding independence.

Qualitative Aspects of the Entity's Significant Accounting Practices

Significant Accounting Policies

Management has the responsibility to select and use appropriate accounting policies. A summary of the significant accounting policies adopted by the Authority is included in Note 1 to the financial statements. There have been no initial selection of accounting policies and no changes in significant accounting policies or their application during the year ended September 30, 2018. No matters have come to our attention that would require us, under professional standards, to inform you about (1) the methods used to account for significant unusual transactions and (2) the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

Significant Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's current judgments. Those judgments are normally based on knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ markedly from management's current judgments.

The most sensitive accounting estimates affecting the financial statements are:

> Management's estimate of useful lives for depreciation and amortization, which is based on past history. We evaluated the key factors and assumptions used to develop the useful lives in determining that it is reasonable in relation to the financial statements taken as a whole.
>
> Management's estimate of the workers' compensation claims payable, which is based on an actuarial analysis performed in 2003 and management's estimate of future costs. We evaluated the key factors and assumptions used to develop the estimated liability in determining that it is reasonable in relation to the financial statements taken as a whole.

Financial Statement Disclosures

Certain financial statement disclosures involve significant judgment and are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the Authority's financial statements relate to:

> The disclosure of accrued workers' compensation claims in Note 6 to the financial statements discusses the future estimated payments on one outstanding workers' compensation claim.

Significant Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management relating to the performance of the audit.

Uncorrected and Corrected Misstatements

For purposes of this communication, professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. Further, professional standards require us to also communicate the effect of uncorrected misstatements related to prior periods on the relevant classes of transactions, account balances or disclosures, and the financial statements. Listed below are uncorrected financial statement misstatements whose effects in the current and prior periods, as determined by management, are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

- None noted.

In addition, professional standards require us to communicate to you all material, corrected misstatements that were brought to the attention of management as a result of our audit procedures. No such misstatements were noted.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a matter, whether or not resolved to our satisfaction, concerning a financial accounting, reporting, or auditing matter, which could be significant to the Authority's financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Representations Requested from Management

We have requested certain written representations from management, which are included in the management representation letter dated March 21, 2019.

Management's Consultations with Other Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters. Management informed us that, and to our knowledge, there were no consultations with other accountants regarding auditing and accounting matters.

Other Significant Matters, Findings or Issues

In the normal course of our professional association with the Authority, we generally discuss a variety of matters, including the application of accounting principles and auditing standards, operating conditions affecting the entity, and operating plans and strategies that may affect the risks of material misstatement. None of the matters discussed resulted in a condition to our retention as the Authority's auditors.

Other Matters

With respect to the supplementary information accompanying the financial statements, we made certain inquiries of management and evaluated the form, content, and methods of preparing the information to determine that the information complies with accounting principles generally accepted in the United States of America, the method of preparing it has not changed from the prior period, and the information is appropriate and complete in relation to our audit of the financial statements. We compared and reconciled the supplementary information to the underlying accounting records used to prepare the financial statements or to the financial statements themselves.

This report is intended solely for the information and use of the Board of Directors and management of the West Volusia Hospital Authority and is not intended to be and should not be used by anyone other than these specified parties.

Very truly yours,

James Moore & Co., P.L.

JAMES MOORE & CO., P.L.

WEST VOLUSIA HOSPITAL AUTHORITY

FINANCIAL STATEMENTS

SEPTEMBER 30, 2018

WEST VOLUSIA HOSPITAL AUTHORITY
FINANCIAL STATEMENTS
SEPTEMBER 30, 2018

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James Moore
Certified Public Accountants and Consultants

INDEPENDENT AUDITORS' REPORT

To the Board of Commissioners,
West Volusia Hospital Authority:

Report on the Financial Statements

We have audited the accompanying financial statements of the governmental activities and major fund of the West Volusia Hospital Authority (the Authority), as of and for the year ended September 30, 2018, and the related notes to the financial statements, which collectively comprise the Authority's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

The Authority's management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Authority's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

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Opinions

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the governmental activities and major fund of Authority as of September 30, 2018, and the respective changes in financial position thereof and the respective budgetary comparison for the general fund for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that management's discussion and analysis, as listed in the table of contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise the Authority's basic financial statements. The schedule of healthcare expenditures is presented for purposes of additional analysis and is not a required part of the basic financial statements.

The schedule of healthcare expenditures is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of healthcare expenditures is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated March 21, 2019, on our consideration of the Authority's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Authority's internal control over financial reporting and compliance.

James Moore & Co., P.L.

Daytona Beach, Florida
March 21, 2019

WEST VOLUSIA HOSPITAL AUTHORITY
MANAGEMENT'S DISCUSSION AND ANALYSIS
SEPTEMBER 30, 2018

BEGIN

END

WEST VOLUSIA HOSPITAL AUTHORITY
BALANCE SHEET / STATEMENT OF NET POSITION
SEPTEMBER 30, 2018

	General Fund	Adjustments	Statement of Net Position
ASSETS			
Cash and cash equivalents	$ 10,887,253	$ -	$ 10,887,253
Taxes receivable	121,920	-	121,920
Prepaid items and deposits	2,000	-	2,000
Property and equipment, net	-	565,225	565,225
Total Assets	$ 11,608,158	$ 565,225	$ 12,173,383
LIABILITIES			
Accounts payable and accrued expenses	$ 855,248	$ -	$ 855,248
Workers' compensation claims payable	-	208,000	208,000
Total Liabilities	$ 855,248	$ 208,000	$ 1,063,248
DEFERRED INFLOWS			
Unavailable revenue - taxes receivable	$ 116,506	$ (116,506)	$ -
FUND BALANCE / NET POSITION			
Fund balance:			
Nonspendable:			
Prepaid items and deposits	$ 2,000	$ (2,000)	$ -
Unassigned	10,634,404	(10,634,404)	-
Net position:			
Investment in capital assets	-	565,225	565,225
Unrestricted	-	10,544,910	10,544,910
Total Fund Balance / Net Position	$ 10,636,404	$ 473,731	$ 11,110,135

The accompanying notes to financial statements
are an integral part of these statements.

WEST VOLUSIA HOSPITAL AUTHORITY
STATEMENT OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCE / STATEMENT OF ACTIVITIES
FOR THE YEAR ENDED SEPTEMBER 30, 2018

	General Fund	Adjustments	Statement of Activities
Revenues			
Ad valorem taxes	$ 20,092,455	$ 27,846	$ 20,120,301
Interest income	67,912	-	67,912
Rental income	68,304	-	68,304
Miscellaneous	203	-	203
Total revenues	20,228,874	27,846	20,256,720
Expenditures / expenses			
Healthcare and other	16,171,399	-	16,171,399
Depreciation	-	28,217	28,217
Total expenditures / expenses	16,171,399	28,217	16,199,616
Excess (deficiency) of revenues over expenditures / operating income (loss)	4,057,475	(371)	4,057,104
Net change in fund balance / net position	4,057,475	(371)	4,057,104
Fund balance / net position, beginning of year	6,578,929	474,102	7,053,031
Fund balance / net position, end of year	$ 10,636,404	$ 473,731	$ 11,110,135

The accompanying notes to financial statements
are an integral part of these statements.

WEST VOLUSIA HOSPITAL AUTHORITY
STATEMENT OF REVENUES, EXPENDITURES AND CHANGES IN FUND BALANCE - BUDGET AND ACTUAL
FOR THE YEAR ENDED SEPTEMBER 30, 2018

	Budgeted Amounts		Actual Amounts	Variance with Final Budget - Positive (Negative)
	Original	Final		
Revenues				
Ad valorem taxes	$ 19,910,000	$ 19,910,000	$ 20,092,455	$ 182,455
Interest income	45,000	45,000	67,912	22,912
Rental income	68,304	68,304	68,304	-
Miscellaneous	-	-	203	203
Total revenues	20,023,304	20,023,304	20,228,874	205,570
Expenditures				
Healthcare	17,974,087	17,974,087	14,460,409	3,513,678
Other	2,049,217	2,049,217	1,710,990	338,227
Total expenditures	20,023,304	20,023,304	16,171,399	3,851,905
Excess (deficiency) of revenues over expenditures	-	-	4,057,475	4,057,475
Fund balance, beginning of year	6,578,929	6,578,929	6,578,929	-
Fund balance, end of year	$ 6,578,929	$ 6,578,929	$ 10,636,404	$ 4,057,475

The accompanying notes to financial statements
are an integral part of this statement.

(1) Summary of Significant Accounting Policies:

The accounting policies of the West Volusia Hospital Authority (the Authority) conform to generally accepted accounting principles applicable to governmental units. The following is a summary of significant policies.

(a) **Reporting entity**—The Authority is a special taxing district in Volusia County, Florida created and incorporated in 1957 by the Legislature of the State of Florida under Chapter 57-2085. The five-member elected Board of Commissioners (the Board) is enabled to acquire, construct, operate and maintain hospitals, healthcare facilities, or contract with third parties for the care of medically indigent persons in the Authority's district, and to levy taxes and issue bonds to finance healthcare facilities' operations, and to participate in other activities to promote the general health of the district.

The Authority has adopted the Governmental Accounting Standards Board (GASB) Codification for the purpose of evaluating its financial statements. Based on the Codification, the Authority has determined that there are no other component units that meet the criteria for inclusion in the Authority's financial statements.

(b) **Government-wide and fund financial statements**—The government-wide financial statements (i.e., the statement of net position and the statement of activities) report information on all of the activities of the Authority. The Authority only has governmental activity and does not engage in any business-type activity. Direct expenses are those that are clearly identifiable with a specific function or segment. General revenues include ad valorem taxes and interest income. Fund financial statements are presented for the Authority's General Fund. The General Fund is considered to be a major fund and is the only fund of the Authority.

(c) **Measurement focus, basis of accounting, and financial statement presentation**—The government-wide financial statements are reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned, and expenses are recorded when a liability is incurred, regardless of the timing of related cash flows. Grants and similar items are recognized as revenue when all eligibility requirements imposed by the grantor have been met.

Governmental fund financial statements are reported using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized when they are both measurable and available. Revenues are considered to be available when they are collectible within the current period or soon enough thereafter to pay liabilities of the current period. For this purpose, the Authority considers revenues to be available if they are collected within 60 days of the end of the current period. Expenditures generally are recorded when a liability is incurred. However, expenditures related to long-term agreements are recorded only when payment is due.

(d) **Budgets**—The Board of Commissioners of the Authority adopts an annual operating budget, which is prepared on a modified accrual basis and can be amended by the Board throughout the year. At the fund level, actual expenditures cannot exceed the budgeted amounts; however, with proper approval by the Board, budgetary transfers between line items can be made. The accompanying budgeted financial statements for the General Fund reflect the final budget authorization amounts, including all amendments.

(1) **Summary of Significant Accounting Policies:** (Continued)

(e) **Cash and cash equivalents**—Cash and cash equivalents consists of cash on hand and on deposit in banks and money market accounts.

(f) **Property and equipment**—Property and equipment purchased in the general fund are recorded as expenditures at the time of purchase. Gifts or contributions are recorded at acquisition value at the time received. It is the policy of the Authority to capitalize property and equipment over $500. Lesser amounts are expensed. Depreciation has been provided on fixed assets as a direct charge using the straight-line method over the estimated useful lives of the various classes of depreciable assets, which ranges from 5 to 40 years.

(g) **Deferred inflows of resources**—In addition to liabilities, the statement of financial position will sometimes report a separate section for deferred inflows of resources. This separate financial statement element, deferred inflows of resources, represents an acquisition of net position or fund balance that applies to future period(s) and so will not be recognized as an inflow of resources (revenue) until that time. Currently, the one item in this category is unavailable revenues, which will be recognized as inflows of resources in the period that the amounts become available.

(h) **Fund Balance**—The Authority reports fund balance in accordance with the GASB Codification. Fund balances are classified as follows:

Nonspendable—Amounts that cannot be spent either because they are not in a spendable form or because they are legally or contractually required to be maintained intact.

Restricted—Amounts constrained to specific purposes by outside parties or enabling legislation.

Committed —Amounts that can be used only for specific purposes determined by a formal action by ordinance or resolution.

Assigned—Amounts that are designated by the Board of Commissioners for a specific purpose.

Unassigned—All amounts not included in other spendable classifications.

When an expenditure is incurred for purposes for which restricted, committed, assigned, and unrestricted fund balance is available, the Authority considers restricted funds to have been spent first, committed funds second, assigned funds third, and unassigned funds last.

Nonspendable fund balance is made up of deposits. The Authority had no restricted or committed fund balance at September 30, 2018.

(i) **Use of estimates**—The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements, and reported amounts of revenues and expenses during the reporting period.

(2) **Reconciliation of Government-Wide and Fund Financial Statement:**

(a) **Explanation of certain differences between the governmental fund balance sheet and the government-wide statement of net position**—Included with the governmental fund balance sheet is a reconciliation between fund balance – total governmental funds and net position – governmental activities as reported in the government-wide statement of net position. These differences, including the recording of the Authority's capital assets and long-term workers' compensation claims liability, and various equity reclassifications, are outlined in the "Adjustments" column on the balance sheet / statement of net position.

(b) **Explanation of certain differences between the governmental fund statement of revenues, expenditures, and changes in fund balances and the government-wide statement of activities**—Included with the governmental fund statement of revenues, expenditures, and changes in fund balances, there is a reconciliation between net changes in fund balances - total governmental funds and changes in net position of governmental activities as reported in the government-wide statement of activities. These differences are included in the "Adjustments" column on the statement of revenues, expenditures, and changes in fund balance / statement of activities and consist of depreciation expense for the year and the full change in available taxes receivable.

(3) **Property Tax Calendar:**

The Authority is a taxing authority in Volusia County, Florida (the County), and pays a fee to the County for the assessment and collection of property taxes. The property tax calendar for the year ended September 30, 2018, is as follows:

Valuation date	January 1
Property appraiser prepares the assessment roll with values as of January 1, submits this preliminary roll for approval by the state and notifies each taxing authority of their respective valuations.	July 1
Each taxing authority holds two required public hearings and adopts a budget and ad valorem tax millage rate for the coming fiscal year.	September
Property appraiser certifies the assessment roll and all real and tangible personal property taxes are due and payable (levy date).	November 1
A notice of taxes is mailed to each property owner on the assessment roll. Taxes may be paid November through March with the following applicable discounts:	November through March

Month	Discount
November	4%
December	3%
January	2%
February	1%
March	0%

All unpaid taxes on real and tangible personal property become delinquent.	April 1
A list of unpaid real and tangible personal property taxes are advertised.	April and May
Tax certificates are sold on all real estate with unpaid real estate property taxes (lien date).	June 1
A court order is obtained authorizing the seizure and sale of personal property, if the taxpayer fails to pay the delinquent personal property taxes.	June

(4) Deposits and Investments:

At September 30, 2018, the carrying amount of the Authority's cash on deposit in its bank accounts was $10,887,253 after any applicable reconciling items such as outstanding checks and deposits in transit. In addition to insurance provided by the Federal Depository Insurance Corporation, deposits are held in banking institutions approved by the State Treasurer of the State of Florida to hold public funds. Under Florida Statutes Chapter 280, Florida Security for Public Deposits Act, the State Treasurer requires all Florida qualified public depositories to deposit with the Treasurer or another banking institution eligible collateral. In the event of failure of a qualified public depository, the remaining public depositories would be responsible for covering any resulting losses. The Authority's deposits at year end are considered insured for custodial credit risk purposes.

The Authority is authorized to invest in investment vehicles, as defined in the written investment policy, which was approved by the Board. The policy specifies the authorized investment vehicles which, among others, include the Local Government Surplus Funds Trust Fund (State Board of Administration, "SBA"), negotiable direct obligations of, or obligations the principal and interest of which are unconditionally guaranteed by the U.S. Government at the then prevailing market price for such securities with remaining maturities not exceeding one year, for certain money market funds and repurchase agreements. The policy also specifies the portfolio allocation, which is intended to meet the Authority's specified goals, in order of priority; safety, liquidity, and yield.

(5) Capital Assets:

Changes in the Authority's capital assets for the years ended September 30, 2018, were as follows:

	Balance October 1, 2017	Increases	Decreases	Balance September 30, 2018
Capital assets not being depreciated:				
Land	$ 145,000	$ -	$ -	$ 145,000
Total capital assets not being depreciated	145,000	-	-	145,000
Capital assets being depreciated:				
Machinery and equipment	252	-	-	252
Buildings	772,848	-	-	772,848
Accumulated depreciation	(324,658)	(28,217)	-	(352,875)
Total capital assets being depreciated, net	448,442	(28,217)	-	420,225
Capital Assets, net	$ 593,442	$ (28,217)	$ -	$ 565,225

Depreciation expense for the year ended September 30, 2018, was $28,217.

(6) Accrued Workers' Compensation Claims:

The Authority has responsibility for workers' compensation claims arising from the period that certain hospitals were under its control, and has accrued $208,000 for the purpose of paying settlements. The amount accrued and represents the recommended reserve for future payments on open claims. Management has performed a detailed analysis of past claim costs, claimant life expectancy, and expected future costs in determining the estimate and considers the reserve, which is for one outstanding claim, to be adequate. This balance has not changed from the previous fiscal year.

(7) Contingencies:

The Authority occasionally faces legal claims incidental to the ordinary course of its operations. In the opinion of management and based on the advice of legal counsel, the ultimate disposition of open inquiries and claims, if any, will not have a material adverse effect on the financial position or results of operations of the Authority.

(8) New Accounting Pronouncements:

The Governmental Accounting Standards Board (GASB) has issued several pronouncements that have effective dates that may impact future financial statements. Listed below are pronouncements with required implementation dates effective for subsequent fiscal years that have not yet been implemented. Management has not currently determined what, if any, impact implementation of the following will have on the financial statements:

(a) GASB issued Statement No. 87, *Leases*, in June 2017. GASB 87 increases the usefulness of governments' financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. The provisions in GASB 87 are effective for periods beginning after December 15, 2019.

WEST VOLUSIA HOSPITAL AUTHORITY
SCHEDULE OF HEALTHCARE EXPENDITURES
FOR THE YEARS ENDED SEPTEMBER 30, 2018 AND 2017

	2018	2017
Expenditures		
Healthcare expenditures		
Baker Act, substance abuse and mental health programs	$ 1,184,104	$ 1,200,679
Hospital indigent care reimbursements	4,835,738	5,350,949
Hospital - physicians services	225,000	160,269
Health Care Responsibility Act reimbursements	315,907	205,756
KidCare outreach	67,934	68,720
Medicaid reimbursements	2,258,770	2,201,317
Pharmacy program	688,819	883,296
Primary care and dental program	1,209,258	1,025,356
Specialty care program	3,316,743	3,827,847
HIV outreach	358,136	376,479
Total healthcare expenditures	14,460,409	15,300,668
Other operating expenditures		
General and administrative	92,692	83,857
Marketing and advertising	5,456	89,310
Third-party administration	546,980	391,558
Eligibility and enrollment oversight	267,307	165,326
Legal	60,250	69,160
Plant and maintenance	4,692	4,587
Professional and accounting fees	71,114	85,810
Tax increment fees - City of DeLand	69,746	38,304
Tax collector and appraiser fees	587,595	409,881
Miscellaneous	5,158	2,205
Total other operating expenditures	1,710,990	1,339,998
Total expenditures	$ 16,171,399	$ 16,640,666

See accompanying notes to financial statements.

James Moore
Certified Public Accountants and Consultants

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Board of Commissioners,
West Volusia Hospital Authority:

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in the *Government Auditing Standards* issued by the Comptroller General of the United States of America, the financial statements of the governmental activities and major fund of the West Volusia Hospital Authority (the Authority) as of and for the year ended September 30, 2018, and the related notes to the financial statements, which collectively comprise the Authority's basic financial statements, and have issued our report thereon dated March 21, 2019

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Authority's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Authority's internal control. Accordingly, we do not express an opinion on the effectiveness of the Authority's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the Authority's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

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Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Authority's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

James Moore & Co., P.L.

Daytona Beach, Florida
March 21, 2019

INDEPENDENT AUDITORS' MANAGEMENT LETTER REQUIRED BY CHAPTER 10.550, RULES OF THE STATE OF FLORIDA OFFICE OF THE AUDITOR GENERAL

To the Board of Commissioners,
West Volusia Hospital Authority:

Report on the Financial Statements

We have audited the basic financial statements of the West Volusia Hospital Authority (the Authority), as of and for the fiscal year ended September 30, 2018, and have issued our report thereon dated March 21, 2019.

Auditors' Responsibility

We conducted our audit in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and Chapter 10.550, Rules of the Florida Auditor General.

Other Reporting Requirements

We have issued our Independent Auditors' Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance with *Government Auditing Standards*; and Independent Accountants' Report on an examination conducted in accordance with *AICPA Professional Standards*, AT-C Section 315, regarding compliance requirements in accordance with Chapter 10.550, Rules of the Auditor General. Disclosures in those reports, which are dated March 21, 2019, should be considered in conjunction with this management letter.

Prior Audit Findings

Section 10.554(1)(i)1., Rules of the Auditor General, requires that we determine whether or not corrective actions have been taken to address findings and recommendations made in the preceding annual financial audit report. No comments from the second preceding year remain uncorrected. Findings and recommendations made in the preceding annual financial audit and their status is summarized below:

2017-001 Funding Agreements: Corrective action not taken. See repeat comment 2018-001.

Official Title and Legal Authority

Section 10.554(1)(i)4., Rules of the Auditor General, requires that the name or official title and legal authority for the primary government and each component unit of the reporting entity be disclosed in this management letter, unless disclosed in the notes to the financial statements. The Authority was established by special act by the Florida Legislature. There are no component units related to the Authority.

121 Executive Circle
Daytona Beach, FL 32114-1180
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133 East Indiana Avenue
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5931 NW 1st Place
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Financial Condition and Management

Sections 10.554(1)(i)5.a. and 10.556(7), Rules of the Auditor General, require us to apply appropriate procedures and communicate the results of our determination as to whether or not the Authority has met one or more of the conditions described in Section 218.503(1), Florida Statutes, and to identify the specific condition(s) met. In connection with our audit, we determined that the Authority did not meet any of the conditions described in Section 218.503(1), Florida Statutes.

Pursuant to Sections 10.554(1)(i)5.c. and 10.556(8), Rules of the Auditor General, we applied financial condition assessment procedures for the Authority. It is management's responsibility to monitor the Authority's financial condition, and our financial condition assessment was based in part on representations made by management and review of financial information provided by same.

Section 10.554(1)(i)2., Rules of the Auditor General, requires that we communicate any recommendations to improve financial management. In connection with our audit, we had the following recommendation:

> **2018-001 – Funding Agreements (Repeat Comment):** During our testing of funding agreements entered into by the Authority, we noted that the reimbursements paid to two of the grantees were in excess of the amount allowable per the funding agreements. While all expenses are reviewed and approved by the Board, we recommend that formal amendments to funding agreements are obtained to document any changes to the original funding amounts and terms.
>
> *Management Response: This issue was discovered while accruing year end payables. Due to the timing of the Commission meetings, the board was unable to discuss this until the January meeting, after the audit work was completed. This will be discussed at the January meeting.*

Additional Matters

Section 10.554(1)(i)3., Rules of the Auditor General, requires us to communicate noncompliance with provisions of contracts or grant agreements, or abuse, that have occurred, or are likely to have occurred, that have an effect on the financial statements that is less than material but warrants the attention of those charged with governance. In connection with our audit, we did not note any such findings.

West Volusia Hospital Authority's Response to Findings

The Authority's response to the findings identified in our audit are described above. The Authority's response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of this Letter

Our management letter is intended solely for the information and use of the Legislative Auditing Committee, members of the Florida Senate and the Florida House of Representatives, the Florida Auditor General, Federal and other granting agencies, and applicable management and the Board of Commissioners, and is not intended to be and should not be used by anyone other than these specified parties.

James Moore & Co., P.L.

Daytona Beach, Florida
March 21, 2019

James Moore
Certified Public Accountants and Consultants

INDEPENDENT ACCOUNTANTS' EXAMINATION REPORT

To the Board of Commissioners,
West Volusia Hospital Authority:

We have examined the West Volusia Hospital Authority's (the Authority) compliance with Section 218.415, Florida Statutes, *Local Government Investment Policies,* for the year ended September 30, 2018. The Authority's management is responsible for the Authority's compliance with those requirements. Our responsibility is to express an opinion on the Authority's compliance based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Authority complied with Section 218.415, Florida Statutes, *Local Government Investment Policies,* for the year ended September 30, 2018, in all material respects. An examination involves performing procedures to obtain evidence about the Authority's compliance with those requirements. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of risks of material noncompliance with those requirements, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

In our opinion, the West Volusia Hospital Authority complied, in all material respects, with the aforementioned requirements for the year ended September 30, 2018.

James Moore & Co., P.L.

Daytona Beach, Florida
March 21, 2019

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Fax: (386) 738-2423

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Fax: (386) 999-0414

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Fax: (386) 736-7934

Pharmacy
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Ste. 5
DeLand, FL 32720
(386) 888-4912
Fax: (386) 269-9950

Administration
1205 S. Woodland Blvd
DeLand, FL 32720
(386) 202-6025
Fax: (386) 269-4149

FAMILY
Health Source

"GROWING WELLNESS IN OUR COMMUNITIES"

Attention Commissioners: February 12, 2019

NEFHS would like to request a review of the report received to determine the actual overages stated. NEFHS analysis and reconciliation on accrual of payments as well as monthly bank statements showing deposits does not reflect the same information or figures as alleged from prior year funding. I would like to request to the Commissioners an opportunity to allow for a discussion and review with DRT on overage amounts. I appreciate your consideration in advance for this request.

NEFHS provides a service to be billed to your TPA – in some cases claims are denied due to eligibility for reimbursements. As noted, services performed DOES NOT (date of service on service claim) always equal PAYMENT until the TPA has properly vetted the claim to ensure payment is due. NEFHS processes claims for services that is then reduced in our application request for funding. This is not money given or funded on any premises unless a SERVICE for care is performed and most importantly eligibility is verified by the WVHA contracted TPA for reimbursement to process and approved for payment by the WVHA contracted CPA.

NEFHS would also like to request to the WVHA Commissioners, a review of NEFHS funding application dated April 2018 and request the "original" funding requested amount submitted timely in April of 2018 be adjusted to the $1,253,930.00. As it appears there will be a need to cover the WVHA Patients without charging patients for Primary care.

NEFHS Budget projections for Primary Care, Pharmacy (Medications) and Prenatal for the past few years have been considerably close to the amounts received. During the July 19, 2018 meeting, the WVHA Commissioners requested the funding agencies review their applications and amend if possible, to help support the efforts to NOT raise the millage rate AGAIN for Health Care related expenses budget year 2018/2019. At the time NEFHS payments received (our records) was relative, by which allowed us to amend and support the efforts in ensuring an opportunity for NEFHS to support the cause to not increase the millage rate again on Tax Payers again. NEFHS responded to the WVHA Commissioners request, via letter August 8, 2018, amending the application by not increasing NEFHS State determined MEDICAID rate (currently using a two-year-old Medicaid rate) and reduced our amount requested for Primary care by $335,608. WVHA is paying below the Medicaid rate and with Pharmacy received discounts and is below the Medicaid rate (MAC) maximum allowable cost of prescription drugs.

NEFHS is a federally funded Health Care Center. NEFHS receive Federal funds that are strictly allowed to be allocated to salaries of our medical team (Section 330 funding). We are not funded to be a free clinic and do not receive nor are authorized to function as a free clinic. Much like the WVHA Commissioners and funded agencies, the Federal Government expects us to ensure we are being fiduciarily responsible in our spending of Federal Tax dollars, by collecting our reimbursement on our charges, whether it is with payers whom we bill (insurance, Medicaid, etc. or our self-pay). Patients are offered a waiver of expenses occasionally and only temporarily thru a thoroughly vetted process (like the WVHA application packet) prior to us providing an incidental waiver care. NEFHS is expected to control cost and ensure those that do not have health benefits are charged and pay based on their income level. That is the only difference of an FQHC to for -profit Health Care Clinics as it relates to Primary Care Services.

In the event reimbursement is not provided or capped by a projected amount within our approved application for services performed and billed: WVHA patients will be transitioned to a self-pay model for their Primary Care, Pre-natal and Pharmacy. This will be a tremendous difference to the WVHA patient's financial liability and would by far increase the ER and Hospital cost, as the access will now present a barrier for their chronic care and medication. Diabetes, Heart Disease. Etc...

The average prescription per WVHA patient is 6 different medications. The average cost of self-pay for office visits with a PCP, Prenatal, will range from $20.00 as the minimal and $65.00 as this highest. Again, this is an estimate based on the income level the participants in the WVHA program are identified within. NEFHS is prepared to ensure we are financially responsible if we perform services to WVHA patients, when NEFHS will not be reimbursed for the (authorized approved amount per budget) thru the 2018/2019 reimbursement agreement(s) with WVHA. NEFHS has established policies and programs Federally approved and confirmed for our self-pay procedures and payments; NEFHS will begin to incorporate the WVHA patients. NEFHS is prepared to schedule and properly notify WVHA patients of the changes with their WVHA Healthcare coverage and allowable cost. WVHA Meeting minutes and documentation will be detailed and provided for clear transparency as to the increase of their cost.

It is not customary nor practical for an organization that provides primary care to accurately determine how many patients will be sick, become sick, develop chronic illnesses, need to change their medicine etc. This population is truly a sick population. We apologize for not having the accuracy to predict the specific healthcare needs and outcomes related to the unknown number of patients becoming eligible and or utilization accuracy specifically of the WVHA patients, although we are dedicated to being on the forefront of the trends, and the changes within the population to ensure our figures become more accurate as possible. NEFHS understands and will continue to support the WVHA Commissioners in their fiduciary responsibility in ensuring we are following our budget and cost to the tax payers.

Please let me how I can help or improve in any way so NEFHS can continue to serve the WVHA patients in the community who are dependent on the reduced cost of care within the WVHA Health program for their medication, Primary care and Prenatal.

National and State statistics, studies and reports continue to urge and prove: Access to Primary Care is by far the most important benefit and need that reduce reentry to ER and Hospital cuts Hospital cost and is fundamental for all lives to have access without financial hardship or barriers.

Sincerely,

Laurie Asbury,
Chief Executive Officer,
Northeast Florida Health Services, Inc.
(NEFHS, dba Family Health Source)
Email: lasbury@familyhealthsource.org

WVHA Payments

Date	Payment	Payor
10/03/17	68,804.75	Pomco
10/03/17	7,216.23	Pomco
10/03/17	1,324.86	Pomco
10/19/17	78,516.08	Pomco
11/14/17	45,591.98	Pomco
11/27/17	37,944.93	Pomco
12/08/17	56,265.60	Pomco
12/11/17	15,249.59	Pomco
12/26/17	28,482.53	Pomco
12/26/17	39,351.07	Pomco
01/08/18	(117.25)	Refund
01/09/18	8,499.39	Pomco
02/06/18	41,197.22	Pomco
02/07/18	119,510.26	Pomco
02/22/18	66,827.79	Pomco
03/01/18	44,781.02	Pomco
03/13/18	33,358.98	Pomco
03/15/18	26,923.33	Pomco
03/21/18	63,554.35	Pomco
04/17/18	35,093.43	Pomco
04/25/18	53,421.05	Pomco
04/27/18	38,144.61	Pomco
05/01/18	17,263.64	Pomco
05/14/18	53,451.86	Pomco
05/23/18	61,461.14	Pomco
05/29/18	79,560.09	Pomco
06/12/18	36,952.91	Pomco
06/20/18	63,823.39	Pomco
06/27/18	44,483.83	Pomco
07/10/18	22,972.71	Pomco
08/15/18	7,917.24	UMR
08/27/18	116.43	Pomco
08/29/18	64,420.22	UMR
09/06/18	102,604.10	UMR
09/12/18	57,893.34	UMR
09/12/18	19,104.62	UMR
10/31/18	42,735.02	Pomco
	1,584,702.34	

Payments Listed Unmatched

01/10/18	26,683.98
07/18/18	232.86
09/27/18	88,685.66
	115,602.50

Payments On Their Sept journal but noted AP 11/30/18 - not rcvd

09/30/18	240.86
09/30/18	1,164.30
09/30/18	1,324.73
09/30/18	111,568.37
	114,298.26

Reversals

09/30/18	78,516.08
09/30/18	1,324.86 *(s/b 1393.53)*
09/30/18	68,804.75
09/30/18	5,630.73
09/30/18	1,585.50
	155,861.92

Payments Not Listed

11/06/17	39,614.50
04/05/18	27,040.58
10/15/18	37,036.74
10/15/18	51,981.57
10/30/18	29,456.79
10/30/18	42,876.67
	228,006.85
unmatched	(115,602.50)
	112,404.35 *could be medicare payments*

	NEFHS	WVHA
BUDGET	1,608,362.00	1,608,362.00
PAYMENTS	-1,700,304.84	-1,651,711.00
REVERSALS	155,861.92	
TOTAL OF CONTRACT	63,919.08	-43,349.00

WEST VOLUSIA HOSPITAL AUTHORITY
WVHA BOARD OF COMMISSIONERS REGULAR MEETING

DeLand City Hall
120 S. Florida Avenue, DeLand, FL
July 19, 2018
DeLand, Florida
5:15 pm

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

Absent:
Commissioner Andy Ferrari

CAC Present:
Voloria Manning
Michael Ray
Elmer Holt
Ann Flowers
Lynn Hoganson

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

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

Approval of Proposed Agenda

There was an amended agenda presented to the Commissioners and general public with amendments to Discussion Items 9. C. D. H. I. and J.

Motion 058 – 2018 Commissioner Guzman motioned to approve the amended agenda Discussion Items 9. C. D. H. I. and J. Commissioner Shepard seconded the motion to approve the amended agenda. The motion passed unanimously.

Consent Agenda

Approval of Minutes – June 21, 2018 Primary Care Application/RFP for HealthCard Approval Process Workshop
- June 21, 2018 Joint Meeting with the CAC

Motion 059 - 2018 Commissioner Girtman motioned to approve the Consent Agenda. Commissioner Shepard seconded the motion. The motion passed unanimously.

Millage Rate – presentation attached
UMR 2017-2018 Budget Forecast
Funding Applications and amounts requested
CAC Member Elmer Holt response to Board inquiry re: Budget restrictions (email dated June 28, 2018 attached)

Mr. Ron Cantlay reviewed the rolled-back millage rate presentation at different HealthCard enrollment levels. Mr. Cantlay stressed to the Commissioners that there really are not enough funds in reserves and any unexpended funds can aide in building that long-term funds reserve.

4:09 p.m. Commissioner Guzman announced that she received a message from Chair Ferrari and that he was in the emergency department at Florida Hospital DeLand and would not be in attendance for tonight's meetings.

4:15 p.m. Commissioner Judy Craig arrived to the meeting. Commissioner Shepard passed the gavel to Vice-Chair Craig.

There was much Board discussion and consent to consider establishing a millage rate slightly higher than the rolled-back rate, with the hope of ultimately adopting the rolled-back rate. Further, there was Board discussion and consent to hold funding at last year's funding limits or closer to last year's funding limits rather than implementing any increases in funding.

CAC Member Elmer Holt addressed the Board explaining that it was a real struggle to assess and make funding recommendations for the WVHA applications for funding, where roughly 4 agencies requested funding increases from 40% up to 120%.

Vice-Chair Craig stated that she was opposed to adopting anything higher than the rolled-back rate.

Commissioner Comments

There was further Board discussion and recommendation that the WVHA funded agencies who rely entirely on WVHA funding need to try and find other sources of funding in addition to the WVHA.

Mr. Cantlay reminded the Board that if they adopted a rate higher than the rolled-back rate it will be published as a preliminary tax increase.

The Board reconsidered and consented that they would adopt the rolled-back rate and keep funding levels at or near the levels of funding during fiscal year 2017-2018.

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

Adjournment

Judy Craig, Vice-Chair

Citizens Comments

There was one.

Citizens Advisory Committee (CAC) – Voloria Manning, Chair

Reporting Agenda

- **POMCO/UMR June 2018 Report – Shawn Jacobs, Strategic Account Executive**

Mr. Shawn Jacobs, Strategic Account Executive, UMR addressed the Board and introduced Donna Lupo, Strategic Account Executive, who works out of UMR's Tampa office and will be taking over as the Strategic Account Executive for the WVHA.

Mr. Jacobs continued by reminding the Board that UMR recommended stalling the implementation of the newly Board approved increased copayment amounts until the beginning of the WVHA new fiscal year on October 1, 2018. He stated that UMR would gladly mail out those notifications; however, UMR wanted the content of that communication to come from the WVHA Board.

Mr. Jacobs brought the Board up to date with the migration from POMCO to UMR and stated that this migration is now complete.

- **FQHC Report - Laurie Asbury, CEO**
  - **Northeast Florida Health Services, Inc. d/b/a Family Health Source (FHS) June Report**

Commissioner Girtman asked Ms. Asbury how NEFHS would be impacted and the WVHA HealthCard members if the Board held their funding at last year's levels?

Ms. Asbury responded that the services will not be denied to any WVHA HealthCard members. Further, NEFHS would like to reduce their primary care rate of reimbursement even lower than the requested Medicaid rate of reimbursement. She asked the Board if NEFHS could adjust their request for funding to reduce the primary care fee for service rate and asked how the Board would like for NEFHS to proceed with this, in an attempt to be a good partner and as concerned tax payers.

There was Board consent, gratitude and direction that Ms. Asbury should edit the original NEFHS WVHA Application for Funding and deliver it to DRT in time for the next Board Meeting of August 16, 2018.

Ms. Long asked Ms. Asbury if she could deliver the revised WVHA Application for Funding by noon on Tuesday, August 7, 2018.

Ms. Asbury confirmed that they would.

Contractual Utilization Reports to the WVHA Board of Commissioners

- **Healthy Communities Outreach Program Steve Parris, Community Health Manager**

Mr. Steve Parris addressed the Board and provided Healthy Communities utilization report for the current fiscal year (attached).

- **The House Next Door (THND) Gail Hallmon, Operations Director**

Ms. Gail Hallmon addressed the Board and provided The House Next Door's contractual utilization report for this current fiscal year (attached).

Discussion Items

CAC Applicant Jenneffer Pulapaka (application attached)

Motion 060 – 2018 Commissioner Girtman motioned to appoint Jenneffer Pulapaka to the CAC as Commissioner Ferrari's appointee. Commissioner Guzman seconded the motion. The motion passed unanimously.

Proposed Millage Rate

Mr. Cantlay displayed the proposed budget as was discussed during the Budget Workshop.

Motion 061 – 2018 Commissioner Shepard motioned to adopt the rolled-back millage rate of 2.1751 to generate $20,319,968.00 in revenues and to adopt Resolution 2018-001. Commissioner Girtman seconded the motion.

Roll Call:

Commissioner Craig	Yes
Commissioner Guzman	Yes
Commissioner Ferrari	Absent
Commissioner Girtman	Yes
Commissioner Shepard	Yes

The Resolution was adopted by a 4-0-1 vote.

Hispanic Health Initiative Request for increased funding $15,000.00 for FY 2017-2018

This matter died for lack of a motion.

Hispanic Health Initiative 17th "Festival de la Familia" Health Fair August 11, 2018

Commissioner Guzman asked Ms. Josephine Mercado, Executive Director, Hispanic Health Initiative if this was a fund raiser for her organization?

Ms. Mercado responded yes.

Motion 062 – 2018 Commissioner Guzman motioned to approve $800.00 for the Hispanic Health Initiative 17th "Festival de la Familia" Health Fair and public awareness campaign. Commissioner Girtman seconded the motion. The motion passed unanimously.

WVHA Tentatively Scheduled Meetings 2018 (attached)

Ms. Long explained that the Initial Budget Hearing of Thursday, September 13, 2018 will be followed by the Special Meeting for the RFP for TPA services, this meeting will be held at DeLand City Hall, 120 S. Florida Avenue, DeLand FL. The Initial Budget Hearing will commence at 5:05 p.m. The Final Budget Hearing will be followed by the Regular Meeting on Thursday, September 27, 2018 and this meeting will be held at the DeLand Police Department in the Community Room, located at 219 W. Howry Avenue, DeLand FL. The Final Budget Hearing will commence at 5:05 p.m.

Motion 063 – 2018 Commissioner Shepard motioned to accept the WVHA Tentatively Scheduled Meetings 2018 as presented. Commissioner Guzman seconded the motion. The motion passed unanimously.

Third Party Administrator (TPA) RFP (draft)
List of online search for TPA's
Special Meeting to commence at the conclusion of the Initial Budget Hearing of Thursday, September 13, 2018

Motion 064 – 2018 Commissioner Guzman motioned to approve the draft of the TPA RFP as amended and presented. Commissioner Shepard seconded the motion.

Mr. Small stated that the list of TPA's that were found online were a good starting point, but he encouraged the Board not to limit the distribution to just that list. He further cautioned the Board not to engage in any direct discussions with any potential RFP bidders, as all communications need to go through DRT.

The motion passed unanimously.

Site Visits 2017-2018 – DRT Engagement Letter (attached)
Florida Department of Health – Dental Services
Rising Against All Odds – 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

Motion 065 – 2018 Commissioner Girtman motioned to accept the DRT Engagement Letter for Site Visits 2017-2018. Commissioner Guzman seconded the motion. The motion passed unanimously.

Reducing Federal Poverty Level (FPL) from current WVHA eligibility criteria at 150% FPL

There was Board discussion in regards to possibly reducing the current FPL level from 150% of FPL to a lower percentage, possibly 145% or 140% and how that could impact the WVHA Budget. The Board asked Ms. Gail Hallmon, THND if this was something that she could track over the next few months?

Ms. Gail Hallmon explained that this was not data that was currently being captured by THND but she stated that she could make a commitment tonight to at least capture one category at 145% of FPL.

Subrogation Settlement

Motion 066 – 2018 Commissioner Shepard motioned to accept the subrogation settlement amount of $795.14. Commissioner Girtman seconded the motion. The motion passed unanimously.

Follow Up Items

There were none.

Financial Report

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

Motion 067 - 2018 Commissioner Girtman motioned to pay bills totaling $2,180,400.53 (See attached). Commissioner Shepard seconded the motion. The motion passed unanimously.

Legal Update

Mr. Theodore Small submitted his legal update memorandum dated July 10, 2018 (See attached).

Commissioner Comments

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

Adjournment

Judy Craig, Vice-Chair

West Volusia Hospital Authority
WVHA BOARD OF COMMISSIONERS REGULAR MEETING
August 16, 2018
5:00 p.m.
DeLand City Hall
120 S. Florida Avenue, DeLand, FL

AGENDA

1. Call to Order
2. Opening Observance followed by a moment of silence
3. Approval of Proposed Agenda
4. Consent Agenda
   A. Approval of Minutes Budget Workshop Meeting July 19, 2018
   B. Approval of Minutes Regular Meeting July 19, 2018
5. Citizens Comments
6. Reporting Agenda
   A. UMR July Report – Written Submission
   B. FQHC Report, Laurie Asbury, CEO, Northeast Florida Health Services, Inc. d/b/a/ Family Health Source (FHS) July Report
7. Hospital Quarterly Report
   A. Florida Hospital DeLand – Lorenzo Brown, CEO and/or Kyle Glass, CFO
   B. Florida Hospital Fish – Rob Deininger, President and/or Eric Ostarly, CFO
8. Contractual Utilization Reports to the WVHA Board of Commissioners
   A. Hispanic Health Initiative, Josephine Mercado, Executive Director
   B. Community Legal Services of Mid-Florida, Robin Hite, Resource Manager and Grants Manager
9. Discussion Items
   A. HealthCard approval Process Proposals
      1. Rising Against All Odds – Prescreening Services
      2. The House Next Door Proposal to approve HealthCard Process
   B. NEFHS Reduction to primary care funding request for fiscal year 2018-2019 (letter dated 8/8/2018 attached)
   C. Review Proposed Budget 2018-2019
   D. Hispanic Health Initiative request for additional funding of $7,500.00 for fiscal year 2017-2018
   E. Communication to WVHA HealthCard population regarding increased copayment amounts
   F. Community Life Center – Outreach Services-Site Visit of Third quarter services not performed due to no invoices submitted since April 2018 ($1,325.00)
   G. Follow Up Items
      1. Reducing Federal Poverty Level (FPL) from current WVHA eligibility criteria at 150% FPL
      2. Quarterly Funding Limit Exhausted-Request for Waiver
         a. Healthy Start Coalition of Flagler & Volusia first quarter underfunded-request for reimbursement $9,313.18 (letter dated 8/6/18 attached)
10. Finance Report
    A. July Financials
11. Legal Update
12. Commissioner Comments
13. Adjournment

WEST VOLUSIA HOSPITAL AUTHORITY
WVHA BOARD OF COMMISSIONERS BUDGET WORKSHOP

DeLand City Hall
120 S. Florida Avenue, DeLand, FL
July 19, 2018
DeLand, Florida
4:00 pm

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

Absent:
Commissioner Andy Ferrari

CAC Present:
Voloria Manning
Michael Ray
Elmer Holt
Ann Flowers
Lynn Hoganson

Others Present:
Attorney for the Authority: Theodore 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 Andy Ferrari and Commissioner Judy Craig had not arrived to the meeting by 4:00 p.m.

Secretary Kathie Shepard established that there was a quorum with Commissioner Girtman, Commissioner Guzman and herself present and proceeded to call the meeting to order. The meeting took place at DeLand City Hall in the Commission Chamber, located at 120 S. Florida Ave., DeLand, Florida, having been legally noticed in the Daytona Beach News-Journal, a newspaper of general circulation in Volusia County.

Approval of Proposed Agenda

Motion 057 – 2018 Commissioner Girtman motioned to approve the agenda. Commissioner Guzman seconded the motion. The motion passed unanimously by Commissioners Girtman, Commissioner Guzman and Commissioner Shepard.

Citizens Comments

There was one.

Discussion Items

FAMILY Health Source

"GROWING WELLNESS IN OUR COMMUNITIES"

Attention Commissioners: August 8, 2018

This letter is to serve as a request for an amendment for Northeast Florida Health Services, Inc., (NEFHS) dba, Family Health Source's funding application for fiscal year 2018-2019. Per WVHA commission meeting, dated July 19, 2018, NEFHS is presenting a reduction in the requested funding amount, that is provided below.

TOTAL PROGRAM COST:	APPLICATION YEAR	AMENDED
Medical	$1,253,930.00	$918,322.00
Pharmacy	$752,281.00	$752,281.00
Prenatal	$32,250.00	$30,000.00

*WVHA FUNDS REQUESTED: $1,700,603.00

AVG COST TO PROGRAM/UNIT OF SERVICE:

Medical:	$115.43
Pharmacy:	$ 29.40

WVHA REIMBURSEMENT RATE:

Medical: $115.43 (after $5.00 copay)
Pharmacy: $752,281.00
Prenatal: 120.43 (2017) Medicaid rate – Reduced from Application

Medical: $120.43 for medical, reimbursement would be $115.43 after the $5.00 co-pay, with the average visit of 720 per month; this would represent a cost of $997,315.20. NEFHS is requesting to receive the same reimbursement awarded for primary care services for the 201-2018 fiscal year which was $918,322.00.

Sincerely,

Laurie Asbury,
Chief Executive Officer
Northeast Florida Health Services Inc.
(NEFHS, dba Family Health Source)
E-mail: lasbury@familyhealthsource.org

AGENDA FOR PUBLIC HEARING TO ADOPT 2017-2018 FINAL MILLAGE RATE AND BUDGET

WEST VOLUSIA HOSPITAL AUTHORITY
DeLand Police Department Community Room
219 W. Howry Avenue, DeLand, FL
Thursday, September 27, 2018, 5:05 p.m.

1. Call to order
2. Establish Quorum
3. Comment by Chair regarding meeting procedure as outlined in 4 and 5 (below)
4. Discussion of the tentatively adopted millage rate of 2.1751, a 0% percentage increase over the rolled-back rate necessary to fund the budget

    A. Public comment regarding proposed in ad valorem tax revenues and millage
    B. Commissioner Discussion
    C. Recompute the proposed millage rate, if necessary based on discussion
    D. Publicly announce the proposed millage and the percent, if any, by which the recomputed proposed millage rate exceeds the rolled-back rate. (The percentage shall be characterized as the percentage increase in property taxes adopted by the Authority). (See attached Public Announcement)
    E. Amend the proposed millage rate, if necessary based on any comments
    F. Publicly read in full the final millage rate Resolution 2018-005
    G. Adopt the final millage rate

5. Discussion of the tentatively adopted operating budget of $20,319,968.00 for fiscal year 2018-2019

    A. Discussion of the proposed budget
    B. Public comment regarding the proposed budget
    C. Commissioner Discussion
    D. Amend the proposed budget, if necessary based on discussion
    E. Publicly read in full the final budget Resolution 2018-006
    F. Adopt the final operating budget

6. Adjournment of the Hearing

West Volusia Hospital Authority
Statement of Revenue and Expenditures

		ANNUAL BUDGET 2018	Per Discussion 9/13/2018
Enrollment			
Revenue			
Ad Valorem Taxes - Proposed rolled-back	2.1751	19,910,000.00	20,194,000.00
Investment Income		45,000.00	55,000.00
Rental Income		68,304.00	70,968.00
Other Income		0.00	
Total Revenue		20,023,304.00	20,319,968.00
Healthcare Expenditures			
Adventist Health Systems		5,655,654.00	5,848,544.00
Northeast Florida Health Services		1,608,362.00	1,700,603.00
Specialty Care		5,208,000.00	4,375,000.00
County Medicaid Reimbursement		2,250,000.00	2,385,000.00
The House Next Door		120,000.00	120,000.00
The Neighborhood Center		70,000.00	70,000.00
Community Life Center Outreach Services		25,000.00	20,000.00
Rising Against All Odds		235,000.00	235,000.00
Community Legal Services		76,931.00	76,931.00
Hispanic Health Initiatives		75,000.00	75,000.00
Deltona Firefighters		75,000.00	-
Florida Dept of Health Dental Svcs		200,000.00	200,000.00
Good Samaritan - Dental		54,747.00	30,000.00
Good Samaritan - Medical		25,000.00	30,000.00
Stewart Marchman - ARNP		7,000.00	-
Stewart Marchman - Baker Act		325,000.00	300,000.00
Stewart Marchman - Treatment		550,000.00	550,000.00
Stewart Marchman - Homeless		64,336.00	64,336.00
Health Start Coalition - Outreach		68,862.00	68,859.00
Health Start Coalition - Family Services		73,500.00	73,500.00
HCRA		819,612.00	819,162.00
Other Healthcare Costs		315,047.00	300,000.00
Total Healthcare Expenditures		17,902,051.00	17,341,935.00
Other Expenditures			
Advertising		12,000.00	5,000.00
Annual Independent Audit		15,800.00	16,000.00
Building & Office Costs		6,500.00	6,500.00
General Accounting		68,100.00	68,100.00
General Administrative		65,100.00	65,100.00
Legal Counsel		70,000.00	70,000.00
Special Accounting		5,000.00	5,000.00
City of DeLand Tax Increment District		75,000.00	100,000.00
Tax Collector & Appraiser Fee		625,740.00	603,880.00
TPA Services		718,560.00	530,000.00
Eligibility / Enrollment		92,170.00	30,000.00
Healthy Communities		72,036.00	72,036.00
Application Screening - THND		189,742.00	317,872.00
Application Screening - RAAO		34,005.00	34,005.00
Application Screening - SMA		14,000.00	14,000.00
Workers Compensation Claims		25,000.00	25,000.00
Other Operating Expenditures		32,500.00	250,000.00
Total Other Expenditures		2,121,253.00	2,182,493.00
Total Expenditures		20,023,304.00	19,524,428.00
Excess (Deficit)		0.00	795,540.00

Hospital	5,598,544.00
Physicians contract	250,000.00
Adventist Health	5,848,544.00

Required payments total 3,529,162.00

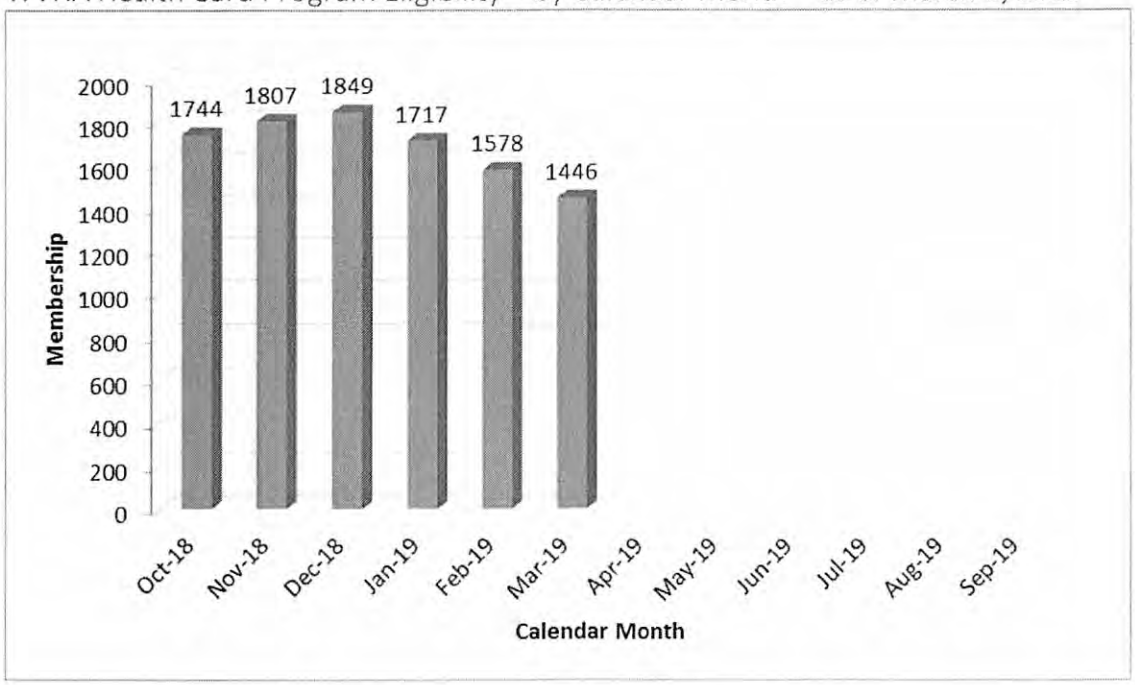
UMR

March 21, 2019

Submission Report for WVHA Board Members

Table of Contents

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

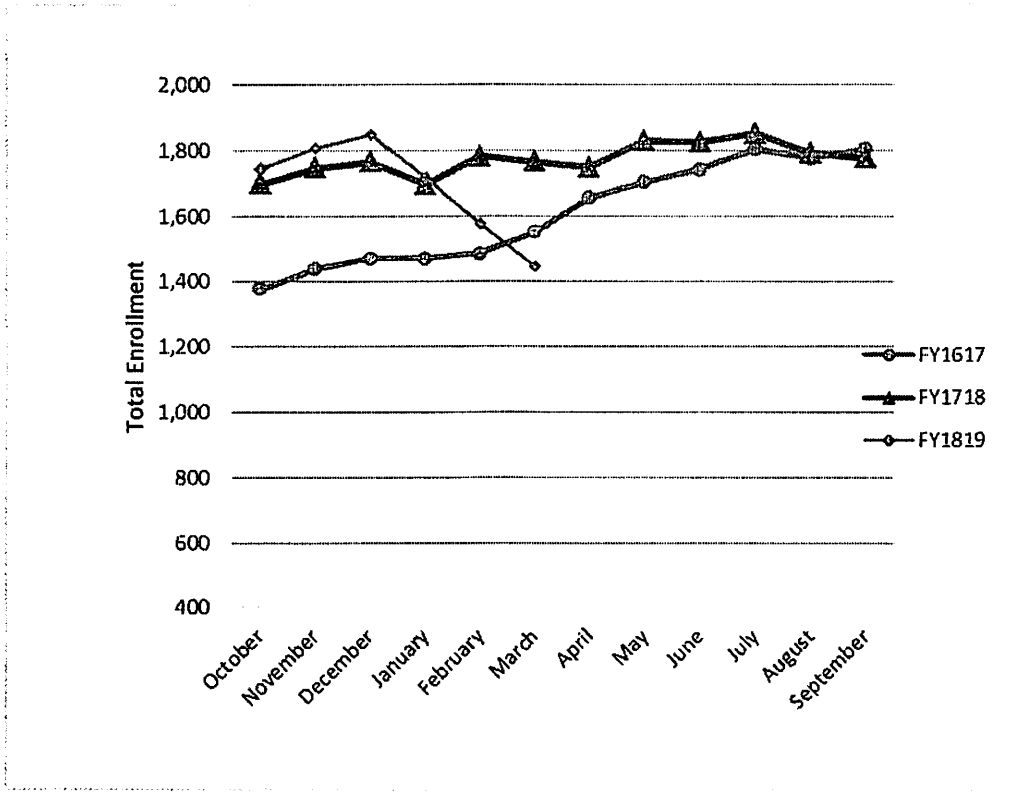


Eligibility reported above reflects eligibility as of the first of each month.

As of March 1, 2019, total program eligibility was 1,446 patients.

WVHA Enrollment by Fiscal Year – as of March 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	1,578
March	1,446
April	
May	
June	
July	
August	
September	
Grand Total	10,141


2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
Total Enrollment
October
November
December
January
February
March
April
May
June
July
August
September
FY1617
FY1718
FY1819

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	$85,000.00	$4,502.16	$89,502.16	2,027	$44.15
January	$66,232.60	$4,930.62	$71,163.22	2,221	$32.04
February					
March					
April					
May					
June					
July					
August					
September					
Grand Total	$261,896.18	$24,102.54	$285,998.72	10,856	$26.34

Combined Medical Costs (as of Claims Payment through 2/28/2019)

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	**$3,872,794.24**	**$215,213.05**	**$345,618.19**	**$1,418,229.20**	**$39,478.62**	**$285,998.72**	**$6,177,332.02**	**8,682**	**$711.51**	**$446.07**	**$24.79**	**$39.81**	**$163.35**	**$32.94**
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	$89,502.16	$812,263.55	1,717	$473.07	$152.03	$37.89	$53.24	$177.79	$52.13
January	$1,068,458.10	$23,389.99	$53,066.17	$287,311.72	$39,478.62	$71,163.22	$1,542,867.82	1,578	$977.74	$677.10	$14.82	$33.63	$182.07	$45.10
February	$2,464,398.16	$36,655.51	$1,991.59	$287,643.00	$0.00		$2,790,688.26	1,731	$1,612.18	$1,423.68	$21.18	$1.15	$166.17	$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	**$3,872,794.24**	**$215,213.05**	**$345,618.19**	**$1,418,229.20**	**$39,478.62**	**$285,998.72**	**$6,177,332.02**	**8,682**	**$711.51**	**$446.07**	**$24.79**	**$39.81**	**$163.35**	**$32.94**

Medical and pharmacy costs are reported on a paid basis

PCP Encounter Claims by Clinic by Month (as of Claims Payment through 2/28/2019)

	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	197	233	55	0	11	496
February	33	26	8	0	3	70
March						0
April						0
May						0
June						0
July						0
August						0
September						0
Grand Total	1,295	1,424	427	0	50	3,196

PCP encounter claims are reported on a paid basis

Specialty Care Services by Specialty – Top 25 (February, 2019)

SPECIALTY CARE SERVICES BY SPECIALTY - TOP 25 FOR FEBRUARY							
Order	**SPECIALTY**	**Unique Patients**	**Claim Volume**		**Paid**		**Cost Per Patient**
1	Internal Medicine	89	190	$	42,487.64	$	223.62
2	Surgery Center	61	67	$	32,843.15	$	490.20
3	Hematology Oncology	35	79	$	26,273.50	$	332.58
4	Physical & Occupational Therapy	47	266	$	19,660.99	$	73.91
5	Radiology	258	532	$	19,650.86	$	36.94
6	Gastroenterology	63	93	$	15,079.63	$	162.15
7	Pulmonary Medicine	41	94	$	12,135.04	$	129.10
8	Pain Management	53	74	$	11,699.94	$	158.11
9	Orthopedic Surgery	65	91	$	11,152.15	$	122.55
10	Cardiovascular Diseases	36	50	$	10,514.70	$	210.29
11	Nurse Anesthetist	73	80	$	9,928.28	$	124.10
12	Infectious Diseases	41	93	$	9,887.66	$	106.32
13	Ophthalmology	51	62	$	8,368.34	$	134.97
14	Family Practice	41	65	$	6,955.30	$	107.00
15	Anesthesiology	49	56	$	6,503.15	$	116.13
16	Neurology	36	44	$	5,295.78	$	120.36
17	Urology	22	31	$	4,440.71	$	143.25
18	General Surgery	6	8	$	3,632.30	$	454.04
19	Cardiology	16	22	$	3,621.95	$	164.63
20	Oncology	20	36	$	3,522.46	$	97.85
21	Nephrology	25	56	$	3,506.68	$	62.62
22	Podiatry	10	23	$	3,468.73	$	150.81
23	Nurse Practitioner	25	29	$	2,587.45	$	89.22
24	Optometry	20	23	$	2,044.28	$	88.88
25	Dermatology	14	16	$	1,965.46	$	122.84

New Items

Upcoming Development – Automated Process for Hospitals Exceeding Budgets

To address the complexities and other challenges that come with the need to stop paying Hospital claims after they've exceeded their annual budgets, our teams have begun working on a project to automate the processes to account for the following:

1. Automatically track hospital paid claim dollars weekly after hitting 75% of the annual budget (currently done manually)
2. Confirm when hospital budget exhausted and tag all subsequent claims with special claim denial coding (currently done with tracking/tagging macros and some human intervention)
3. Batch all claims with the special denial code directly after the start of the new fiscal to be reprocessed in special batch for funding request (previously done via an automatic process under POMCO systems but currently cannot be done as a special cumulative batch on UMR platform)

We believe the project to address the items above should help to produce a more efficient, accurate and automated process and thus prevent delays in reprocessing the hospital claims previously denied for exhausting their budget.

This project is scheduled to be completed early summer 2019 with the expectation that the current hospital budget may be exhausted by late August or early September of 2019.

Account Management Transition to UnitedHealthcare/UMR's Florida Health Plan

As a follow-up to our discussion last year regarding UnitedHealthcare's Account Management alignment by territory and health plan as well as our introduction of Donna Lupo, we have now entered the stage were Donna Lupo will begin leading the Account Management team assigned to the West Volusia Hospital Authority replacing Shawn Jacobs.

The expected timeframe for transitioning will be as follows:

- Donna Lupo will be the main contact effective April 1, 2019 with Shawn Jacobs as a back-up copied on relative strategic plan administration communications and assume related responsibilities; including the submission of the UMR monthly report
- Shawn Jacobs will continue in the above mentioned capacity until July 1, 2019 at which time Donna Lupo will assume full responsibility as the Account Management lead of the WVHA health card program
- Donna Lupo will continue to have access to Shawn Jacobs as needed throughout calendar year 2019
- With the exception of the Director of Account Management, Strategic Account Executive and Field Account Management contact roles, all other subject matter experts currently assigned to support the WVHA health card program will remain the same until further notice

As we move through the above stages, we will assess any gaps or additional needs in the Account Management structure to determine if the timing or any currently assigned subject matter experts would need to be changed accordingly.

A new UMR Account Management contact list for the WVHA health card program will be provided.

UMR
A UnitedHealthcare Company

115 W Wausau Ave
Wausau WI 54401-2875

PO Box 8046
Wausau WI 54402-8046

WEST VOLUSIA HOSPITAL AUTHORITY

February 22, 2019

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, will be the basis for the administration of your Health Plan.

Also enclosed is the Acceptance Page, which formally approves the plan document. 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, whether or not a signature is received.**

If you want UMR to print your SPD or post it to the UMR member web portal, please understand that we cannot do so until we receive a signed Acceptance Page. It is also important that the information in your formally approved plan document agrees with any material distributed to your employees since this document will contain the terms of plan coverage.

Any applicable stop loss policies typically rely on the last formally approved plan document when determining coverage. If the plan document distributed to your employees does not accurately describe the way your plan is actually being administered, the result can be a lapse or delay in stop loss coverage. **Important:** To prevent such lapses or delays in coverage, be sure to return the signed Acceptance Page to your UMR strategic account executive as soon as possible. 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 of plan terms and conditions. Please keep a copy for your records.

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

Thank you for your business.

Diane Gabbard
Case Installations
Enclosure

UMR

A UnitedHealthcare Company

SUMMARY OF MODIFICATIONS

As requested, effective January 1, 2019, change(s) were made to your Health Plan document. The change(s) are shaded in the plan document, with the exception of deleted wording.

- Completed revisions as specified in documents provided to UMR.
- Medical Schedule of Benefits, Benefit Plan(s) 001: Revised coverage of Chiropractic Care

ACCEPTANCE PAGE

Health Plan
7670-00-413413

WEST VOLUSIA HOSPITAL AUTHORITY acknowledges that we have reviewed the plan document for the plan period effective July 1, 2018, January 1, 2017, October 1, 2018, and January 1, 2019, 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

Effective: 01-01-2019

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 member of WEST VOLUSIA HOSPITAL AUTHORITY, and WVHA is pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Administrative Support, DRT or someone at Your PCP or THND or RAAO 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.

WVHA assumes the sole responsibility for funding the Plan benefits out of tax revenues; however, members 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 WVHA 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

Effective: 01-01-2019

Plan Name	WEST VOLUSIA HOSPITAL AUTHORITY GROUP HEALTH BENEFIT PLAN
Name And Address Of 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
WVHA 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	Benefits begin on January 1 and end on the following December 31. For new members and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year per UMR systems and each health card member is only covered for 6 months.
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 contracted with the Third Party Administrator to perform certain responsibilities. 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, 01-01-2019

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% Of Allowed Charges	
Cardiac Pulmonary Rehabilitation: • Maximum Visits Per Lifetime • Paid By Plan	36 Visits 100% Of Allowed Charges	No Benefit
Cardiac Rehabilitation Phase 1 & 2: • Maximum Visits Per Occurrence • Paid By Plan	3 Visits Per Week To A Maximum Of 18 Consecutive Weeks 100% Of Allowed Charges	No Benefit
Chiropractic Care: • Paid By Plan ***Note: No Annual Visit Maximum Applies To This Service; However, Medical Necessity Will Be Reviewed After 25 Visits.***	100% Of Allowed Charges	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% Of Allowed Charges	No Benefit

Effective: 01-01-2017, 10-01-2018, 01-01-2019	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment:		No Benefit
Urgent Care Only:		
• Paid By Plan	100% Of Allowed Charges	
Urgent Care Physician Only:		
• Co-pay Per Visit - Primary Care Physician	$5	
• Co-pay Per Visit - Specialist	$10	
• Paid By Plan	100% Of Allowed Charges	
Note: One Co-pay Applies Per Provider Per Day For Any Physician Charge.		
Emergency Room Only:		
• Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours)	$25	
• Paid By Plan	100% Of Allowed Charges	
Emergency Physicians Only:		
• Paid By Plan	100% Of Allowed Charges	
Hospital Services:		No Benefit
Pre-Admission Testing:		
• Paid By Plan	100% Of Allowed Charges	
Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:		
• Paid By Plan	100% Of Allowed Charges	
Outpatient Services / Outpatient Physician Charges:		
• Co-pay Per Visit	$10	
• Paid By Plan	100% Of Allowed Charges	
Outpatient Advanced Imaging Charges:		
• Co-pay Per Visit	$10	
• Paid By Plan	100% Of Allowed Charges	
Outpatient Lab And X-Ray Charges:		
• Co-pay Per Visit	$10	
• Paid By Plan	100% Of Allowed Charges	

Effective: 01-01-2017, 10-01-2018, 01-01-2019	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgery / Surgeon Charges: • Co-pay Per Visit • Paid By Plan ***Note: One Co-pay Applies Per Provider Per Day For Any Physician Charge.***	$10 100% Of Allowed Charges	
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% Of Allowed Charges	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% Of Allowed Charges	No Benefit
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits: **Inpatient Services / Physician Charges:** • Paid By Plan **Residential Treatment:** • Paid By Plan **Outpatient Or Partial Hospitalization Services Only:** • Paid By Plan **Outpatient Or Partial Hospitalization Physician Only:** • Maximum Visits Per Day • Paid By Plan	 100% Of Allowed Charges 100% Of Allowed Charges 100% Of Allowed Charges 1 Visit 100% Of Allowed Charges	No Benefit

Effective: 01-01-2017, 10-01-2018, 01-01-2019	IN-NETWORK	OUT-OF-NETWORK
Office Visit: • 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.*** ***Note: Medical Necessity Of Outpatient Therapy Services Will Be Reviewed After 25 Visits For Speech Therapy And Occupational Therapy.***	 $5 $10 100% Of Allowed Charges	
Physician Office Services: • 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.*** ***Note: Co-pay Waived For OB/GYN. Referral Required For Specialist Coverage.***	 $5 $10 100% Of Allowed Charges	No Benefit
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: • Co-pay Per Exam - Primary Care Physician • Co-pay Per Exam - Specialist ***Note: One Co-pay Applies Per Provider Per Day For Any Physician Charge.*** **Preventive / Routine Physical Exams At Appropriate Ages:** • Paid By Plan **Immunizations:** • Paid By Plan ***Note: Foreign Travel Immunizations Will Not Be Covered.*** **Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:** • Paid By Plan **Preventive / Routine Mammograms And Breast Exams:** • Maximum Exams Per Calendar Year Including 3D Mammograms For Preventive Screenings • Paid By Plan	 $5 $10 100% Of Allowed Charges 100% Of Allowed Charges 100% Of Allowed Charges 1 Exam 100% Of Allowed Charges	No Benefit

Effective: 01-01-2017, 10-01-2018, 01-01-2019	IN-NETWORK	OUT-OF-NETWORK
3D Mammograms For Preventive Screenings: Included In Preventive / Routine Mammograms And Breast Exams Maximum • Paid By Plan	100% Of Allowed Charges	
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit: • Paid By Plan	100% Of Allowed Charges	
Preventive / Routine Pelvic Exams And Pap Tests: • Maximum Exams Per Calendar Year • Paid By Plan	1 Exam 100% Of Allowed Charges	
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% Of Allowed Charges	
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons: From Age 50 • Paid By Plan	100% Of Allowed Charges	
Therapy Services: **Occupational / Physical / Speech Outpatient Hospital Therapy:** • Paid By Plan	100% Of Allowed Charges	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% Of Allowed Charges	
All Other Covered Expenses: • Paid By Plan	100% Of Allowed Charges	No Benefit

PROVIDER NETWORK

Effective: 01-01-2019

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.

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.

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, 01-01-2019

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 must 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 the 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.

Effective: 01-01-2019	
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 NEFHS Pharmacy.
Dental Services	Reimbursed when services are rendered at the participating Hospitals (Fish Memorial and Florida Hospital Deland).
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 member 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 member 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.

MENTAL HEALTH BENEFITS

Effective: 01-01-2019

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.

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.

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

Effective: 01-01-2019

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.

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.

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.

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 member.

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

Effective: 01-01-2019

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. 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. (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:

- 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;

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 who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

Effective: 01-01-2019

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

UMR 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, UMR 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, UMR 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 UMR may share a Covered Person's PHI with WVHA or the Plan Administrator, and limits the Uses and Disclosures that WVHA or the Plan Administrator may make of a Covered Person's PHI.

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

WVHA or the Plan Administrator 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 UMR.

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

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

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

- WVHA or the Plan Administrator 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 UMR;

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

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

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

- WVHA or the Plan Administrator will promptly report to UMR any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

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

- WVHA or the Plan Administrator and UMR 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;

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

- WVHA or the Plan Administrator will amend or correct, or make available to UMR 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;

- WVHA or the Plan Administrator 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. WVHA or the Plan Administrator does not have to maintain a log if Disclosures are for certain UMR-related purposes such as Payment of benefits or Health Care Operations;

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

- WVHA or the Plan Administrator must, if feasible, return to UMR or destroy all of a Covered Person's PHI that WVHA or the Plan Administrator received from or on behalf of UMR when WVHA or the Plan Administrator 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, WVHA or the Plan Administrator agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

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

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

Administrative Support or DRT, Certified Public Accountant, Enrollment Pre-Screeners

This list includes THND, RAAO, NEFHS, DRT, Florida Hospital Deland, Fish Memorial Hospital, WVHA Attorney, and UMR under the control of WVHA or the Plan Administrator who may receive a Covered Person's PHI. If any of these members or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the members or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If WVHA or the Plan Administrator becomes aware of any such violation, WVHA or the Plan Administrator will promptly report the violation to UMR and will cooperate with UMR to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

Effective: 01-01-2019

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 UMR. 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 UMR 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.

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

WVHA or the Plan Administrator 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 UMR 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

Effective: 01-01-2019

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, WVHA 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 WVHA.

GLOSSARY OF TERMS

Effective: 01-01-2019

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 covered 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 a member: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the member'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 member, 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.

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.

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.

Effective: 01-01-2019

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.

Enrollment Date means:

- For anyone who applies for coverage when first covered, 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.

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; 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.

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.

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.

Member means a covered person or Dependent who is enrolled under this Plan.

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.

Plan means the WEST VOLUSIA HOSPITAL AUTHORITY HEALTH CARD PROGRAM.

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).

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.

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.

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 a member is prevented from engaging in any job or occupation for wage or profit for which the member 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 a member or Dependent who is otherwise covered 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 member.

76-413413 - West Volusia Hospital Auth - Fund Gr

Start Date: 1/25/2019
End Date: 2/7/2019
Check Group: All

Grand Total Invoice $2,043,520.19

	Amount	
Family Health Source OB/GYN	$0.00	
Family Health Source Daytona	$230.86	540
Family Health Source Deland	$646.15	540
Family Health Source Deltona	$425.00	540
Family Health Source Pierson	$230.86	540
Florida Hospital Deland	$963,357.96	509
ACA Advance-FHD	$0.00	
FHD Physician Services	$0.00	
Florida Hospital Fish Memorial	$941,702.46	509.1
ACA Advance-FHFM	$0.00	
FHFM Physician Services	$0.00	
Laboratory Services	$15,045.68	542
Specialty Care Services	$121,881.22	525
Pharmacy Non-Claim Payments/Checks	$0.00	
Claims Check Run Total:	$2,043,520.19	
*TOTAL INVOICE:	$2,043,520.19	

540 $1,532.87

Paid Amount 2/14/2019 ck#15369 $138,459.77 $138,459.77
balance remaining $1,905,060.42

Deny FHD $674,624.11 Claims older 90 day -$674,624.11
Deny FHFM $680,743.28 Claims older 90 days -$680,743.28
Accrued Back to 2017-2018 Hosital Budget $549,693.03

230050 - West Volusia Hospital Authority
Bank Account Reconciliation Worksheet

Intracoastal - Oper

February 1, 2019 - February 28, 2019

Reference	Date	GL Account	Description		Amount
Bank Statement Information					
				Beginning Bank Balance	1,214,065.28
Cleared Deposits & Additions					
1090	02/13/19		West Volusia Hospital Authority		2,097,239.73
CR1	02/13/19	Multiple	Ad Valorem		299,090.90
CR2	02/21/19	Multiple	Ad Valorem		98,837.80
CR6	02/28/19	410	Bank Interest		59.03
				Total	2,495,227.46
				Statement Total	2,495,227.46
				Difference	0.00
Cleared Checks & Payments					
15290	11/28/18	537.2	Healthy Communities		4,973.03
15307	12/12/18	537.2	Healthy Communities		7,512.57
15338	01/14/19	537.2	Healthy Communities		5,381.22
15357	01/30/19	Multiple	UMR		647,550.16
15358	01/30/19	725	UMR		34,609.30
15359	01/30/19	725	UMR		5,805.50
15360	02/13/19	710.4	James Moore & Co., PL		13,100.00
15363	02/13/19	533	Halifax Medical Center		880.18
15364	02/13/19	533	Halifax Medical Center		1,352.30
15367	02/13/19	523	UMR		71,163.22
15369	02/14/19	Multiple	UMR		138,459.77
15370	02/21/19	538	SMA Healthcare		78,186.40
15371	02/21/19	539	SMA Healthcare		25,722.83
15372	02/21/19	530	SMA Healthcare		8,304.24
15375	02/21/19	544	Rising Against All Odds		15,950.00
15376	02/21/19	721.1	Rising Against All Odds		3,456.00
15377	02/21/19	Multiple	Dreggors, Rigsby & Teal, P.A.		5,868.75
15378	02/21/19	710.1	Dreggors, Rigsby & Teal, P.A.		5,723.75
15381	02/21/19	543	The Neighborhood Center		7,800.00
15386	02/21/19	529.3	Florida Department of Health		22,044.10
15387	02/21/19	612	V.W. Gould Agency		1,050.00
15388	02/21/19	710	Theodore W Small PA		5,020.00
15389	02/21/19	760	News-Journal Corp.		143.01
				Total	1,110,056.33
				Statement Total	1,110,056.33
				Difference	0.00
				Ending Bank Balance	2,599,236.41
Reconciled Bank Information					
				Ending Bank Balance	2,599,236.41
Open Deposits & Additions					
CR3	02/28/19	Multiple	Ad Valorem		2,362.48
				Total	2,362.48
Open Checks & Payments					
15361	02/13/19	798	County of Volusia		69,711.10
15362	02/13/19	531	County of Volusia		195,966.47
15365	02/13/19	534	Central Florida Regional Hospital		4,530.83
15366	02/13/19	534	Central Florida Regional Hospital		4,339.84
15373	02/21/19	721	House Next Door		31,013.83
15374	02/21/19	528	House Next Door		7,855.78
15379	02/21/19	730	Adventist Health System		6,038.99
15380	02/21/19	537.2	Healthy Communities		5,343.47
15382	02/21/19	549	The Healthy Start CFVC Inc		6,929.20
15383	02/21/19	548	The Healthy Start CFVC Inc		6,502.56

76-413413 - West Volusia Hospital Auth - Fund Grouping

Start Date: 2/8/2019
End Date: 2/14/2019
Check Group: All

Grand Total Invoice $287,174.19

	Amount	
Family Health Source OB/GYN	$0.00	
Family Health Source Daytona	$0.00	
Family Health Source Deland	$0.00	
Family Health Source Deltona	$0.00	
Family Health Source Pierson	$0.00	
Florida Hospital Deland	$63,938.17	509
ACA Advance-FHD	$0.00	
FHD Physician Services	$0.00	
Florida Hospital Fish Memorial	$87,695.26	509.1
ACA Advance-FHFM	$0.00	
FHFM Physician Services	$0.00	
Laboratory Services	$7,873.38	542
Specialty Care Services	$56,504.16	525
Pharmacy Non-Claim Payments/Checks	$71,163.22	paid 2/13/2019 ck #015367
Claims Check Run Total:	$287,174.19	
*TOTAL INVOICE:	$287,174.19	

Amount Due	$216,010.97	
deny FHD claim #18207186842 2018/7 $331.49	-$331.48	
deny FHFM claim #18195118119 2018/7 $3,047.85	-$3,047.85	
		currently not funded-UMR stated they could not
Payment Due	**$212,631.64**	process partial payments

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

By: _____

Authorized Signature

Print Name: _____

Print Title: _____

Date: _____

UMR, Inc.
400 E. Business Way, Suite 100
Cincinnati, OH 45241

By: _____

Authorized Signature

Print Name: _____

Print Title: _____

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.

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 applicants for benefits 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 distribute to 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. 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 fees (outlined in Exhibit B), UMR can change the fees on each Renewal Term; 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 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 shall notify and consult with Customer but UMR has the final authority and discretion to reasonably determine whether any such Tax should be paid or disputed in a manner consistent with UMR's fiduciary obligations under Section 2.1. 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.

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 (A) in the performance of Customer's or its vendors', subcontractors, or authorized agents' obligations under this Agreement or (B) in the performance of Customer's or its vendors', subcontractors', or authorized agents' obligations under any other agreements entered into by UMR with third parties on Customer's behalf as directed by the Customer.

(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 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 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. 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 such Plan Benefit Litigation in a manner consistent with UMR's fiduciary obligations on UMR's litigation strategy.

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;

(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 shall be provided both via electronic means 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.

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.

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 to include contractual liability; Personal Injury and Broad Form Property Damage coverages;
Independent Contractors;

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 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.

UMR to follow 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 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.

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 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.

Payment Authorization. Authorization to release payments drawn on 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.

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.
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.
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	

Service	Comments
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, 2021. 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.

Service Code	ITEM	FEE and BASIS
	Medical Fees	
0001	Base Medical Fee	$21.55 PEPM in 2019 $22.09 PEPM in 2020 $22.64 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	
0140	Claim Reprocessing	No Charge
	Other Fees	
0720	Referral Tracking	No Charge
1501	Assume Claims Fiduciary Responsibility	No Charge

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

"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**		

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

West Volusia Hospital Authority
Financial Statements
February 28, 2019

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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 February 28, 2019 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

March 04, 2019

West Volusia Hospital Authority
Balance Sheet
Modified Cash Basis
February 28, 2019

Assets

Current Assets		
Petty Cash	$	100.00
Intracoastal Bank - Money Market		10,177,769.66
Intracoastal Bank - Operating		2,250,686.08
Mainstreet Community Bank - MM		10,491,543.57
Taxes Receivable		92,073.00
Total Current Assets		**23,012,172.31**
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		**23,635,830.74**

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		10,444,019.53
Restricted Fund Balance		208,000.00
Nonspendable Fund Balance		621,658.43
Net Income Excess (Deficit)		12,268,382.78
Total Net Assets		**23,542,060.74**
Total Liabilities and Net Assets	$	**23,635,830.74**

See Accountants' Compilation Report

West Volusia Hospital Authority
Statement of Revenue and Expenditures
Modified Cash Basis
Budget and Actual
For the 1 Month and 5 Months Ended February 28, 2019

	Annual Budget	Current Period Actual	Year To Date Actual	Budget Balance
Revenue				
Ad Valorem Taxes	20,194,000	408,390	18,057,862	2,136,138
Investment Income	55,000	15,213	51,052	3,948
Rental Income	70,968	0	28,460	42,508
Total Revenue	**20,319,968**	**423,603**	**18,137,374**	**2,182,594**
Healthcare Expenditures				
Adventist Health Systems	5,848,544	0	1,494,297	4,354,247
Northeast Florida Health Services	1,700,603	72,696	516,627	1,183,976
Specialty Care	4,375,000	136,927	1,077,944	3,297,056
County Medicaid Reimbursement	2,385,000	195,966	979,832	1,405,168
The House Next Door	120,000	7,856	34,785	85,215
The Neighborhood Center	70,000	7,800	30,900	39,100
Community Life Center Outreach Services	20,000	0	550	19,450
Rising Against All Odds	235,000	15,950	60,528	174,472
Community Legal Services	76,931	7,948	18,989	57,942
Hispanic Health Initiatives	75,000	4,725	14,800	60,200
Florida Dept of Health Dental Svcs	200,000	22,044	82,581	117,419
Good Samaritan	60,000	0	0	60,000
Stewart Marchman - ACT	925,336	112,213	434,667	490,669
Health Start Coalition of Flagler & Volusia	142,359	13,432	40,399	101,960
H C R A	819,612	11,103	38,773	780,839
Other Healthcare Costs	1,095,090	0	0	1,095,090
Total Healthcare Expenditures	**18,148,475**	**608,660**	**4,825,672**	**13,322,803**
Other Expenditures				
Advertising	5,000	143	3,060	1,940
Annual Independent Audit	16,000	13,100	13,100	2,900
Building & Office Costs	6,500	1,058	2,698	3,802
General Accounting	68,100	5,724	23,809	44,291
General Administrative	65,100	5,038	13,553	51,547
Legal Counsel	70,000	5,020	17,020	52,980
Special Accounting	5,000	0	0	5,000
City of DeLand Tax Increment District	100,000	0	72,444	27,556
Tax Collector & Appraiser Fee	603,880	77,810	501,533	102,347
TPA Services	500,000	0	264,925	235,075
Eligibility / Enrollment	30,000	0	4,221	25,779
Healthy Communities	72,036	5,343	23,210	48,826
Application Screening				
Application Screening - THND	317,872	31,014	78,449	239,423
Application Screening - RAAO	34,005	3,456	17,280	16,725
Application Screening - SMA	3,000	0	0	3,000
Workers Compensation Claims	25,000	6,039	6,039	18,961
Other Operating Expenditures	250,000	831	1,979	248,021
Total Other Expenditures	**2,171,493**	**154,576**	**1,043,320**	**1,128,173**
Total Expenditures	20,319,968	763,236	5,868,992	14,450,976
Excess (Deficit)	**0**	**(339,633)**	**12,268,382**	**(12,268,382)**

See Accountants' Compilation Report

West Volusia Hospital Authority
Schedule I - Healthcare Expenditures
Modified Cash Basis
Budget and Actual
For the 1 Month and 5 Months Ended February 28, 2019

	Annual Budget	Current Period Actual	Year To Date Actual	Budget Balance
Healthcare Expenditures				
Adventist Health Systems				
Florida Hospital DeLand	2,811,772	0	757,627	2,054,145
Florida Hospital Fish Memorial	2,811,772	0	697,192	2,114,580
Florida Hospital DeLand - Physicians	112,500	0	21,916	90,584
Florida Hospital Fish - Physicians	112,500	0	17,563	94,937
Northeast Florida Health Services				
NEFHS - Pharmacy	752,281	71,163	285,999	466,282
NEFHS - Obstetrics	30,000	0	18,180	11,820
NEFHS - Primary Care	918,322	1,533	212,448	705,874
Specialty Care	4,375,000	136,927	1,077,944	3,297,056
County Medicaid Reimbursement	2,385,000	195,966	979,832	1,405,168
Florida Dept of Health Dental Svcs	200,000	22,044	82,581	117,419
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	7,856	34,785	85,215
The Neighborhood Center	70,000	7,800	30,900	39,100
Community Life Center Outreach Services	20,000	0	550	19,450
Rising Against All Odds	235,000	15,950	60,528	174,472
Community Legal Services	76,931	7,948	18,989	57,942
Hispanic Health Initiatives	75,000	4,725	14,800	60,200
Stewart Marchman - ACT				
SMA - Homeless Program	75,336	8,304	33,346	41,990
SMA - Residential Treatment	550,000	78,186	317,502	232,498
SMA - Baker Act - Match	300,000	25,723	83,818	216,182
Health Start Coalition of Flagler & Volusia				
HSCFV - Outreach	73,500	6,503	14,313	59,187
HSCFV - Fam Services	68,859	6,929	26,086	42,773
HCRA				
H C R A - In County	400,000	2,232	22,046	377,954
H C R A - Outside County	419,612	8,871	16,727	402,885
Other Healthcare Costs	1,095,090	0	0	1,095,090
Total Healthcare Expenditures	**18,148,475**	**608,660**	**4,825,672**	**13,322,803**

West Volusia Hospital Authority
Schedule II - Statement of Revenue and Expenditures
Modified Cash Basis
For the 1 Month and 5 Months Ended February 28, 2019 and February 28, 2018

	1 Month Ended February 28, 2019	1 Month Ended February 28, 2018	5 MonthsEnded February 28, 2019	5 Months Ended February 28, 2018
Revenue				
Ad Valorem Taxes	408,390	381,410	18,057,862	17,827,917
Investment Income	15,213	5,935	51,052	21,529
Rental Income	0	5,692	28,460	28,460
Other Income	0	0	0	203
Total Revenue	423,603	393,037	18,137,374	17,878,109
Healthcare Expenditures				
Adventist Health Systems	0	518,583	1,494,297	2,984,602
Northeast Florida Health Services	72,696	264,478	516,627	556,597
Specialty Care	136,927	258,022	1,077,944	1,039,282
County Medicaid Reimbursement	195,966	185,652	979,832	928,261
The House Next Door	7,856	8,483	34,785	34,292
The Neighborhood Center	7,800	8,175	30,900	31,325
Community Life Center Outreach Services	0	5,550	550	5,550
Rising Against All Odds	15,950	16,375	60,528	75,125
Community Legal Services	7,948	2,742	18,989	11,270
Hispanic Health Initiatives	4,725	10,225	14,800	43,475
Deltona Firefighters Foun Access to Hlth	0	383	0	383
Florida Dept of Health Dental Svcs	22,044	30,348	82,581	108,167
Good Samaritan	0	4,058	0	15,458
Stewart Marchman - ACT	112,213	92,640	434,667	324,644
Health Start Coalition of Flagler & Volusia	13,432	9,889	40,399	44,898
H C R A	11,103	11,975	38,773	33,502
Total Healthcare Expenditures	**608,660**	**1,427,578**	**4,825,672**	**6,236,831**
Other Expenditures				
Advertising	143	498	3,060	1,096
Annual Independent Audit	13,100	3,800	13,100	15,800
Building & Office Costs	1,058	926	2,698	2,857
General Accounting	5,724	5,059	23,809	25,030
General Administrative	5,038	6,620	13,553	19,765
Legal Counsel	5,020	6,860	17,020	23,930
City of DeLand Tax Increment District	0	0	72,444	69,746
Tax Collector & Appraiser Fee	77,810	100,134	501,533	450,214
TPA Services	0	27,250	264,925	197,823
Eligibility / Enrollment	0	5,796	4,221	18,480
Healthy Communities	5,343	5,057	23,210	22,481
Application Screening				
Application Screening - THND	31,014	15,812	78,449	63,247
Application Screening - RAAO	3,456	3,456	17,280	8,256
Application Screening - SMA	0	358	0	1,785
Workers Compensation Claims	6,039	0	6,039	16,249
Other Operating Expenditures	831	906	1,979	1,294
Total Other Expenditures	**154,576**	**182,532**	**1,043,320**	**938,053**

See Accountants' Compilation Report

West Volusia Hospital Authority
Schedule II - Statement of Revenue and Expenditures
Modified Cash Basis
For the 1 Month and 5 Months Ended February 28, 2019 and February 28, 2018

	1 Month Ended February 28, 2019	1 Month Ended February 28, 2018	5 MonthsEnded February 28, 2019	5 Months Ended February 28, 2018
Total Expenditures	763,236	1,610,110	5,868,992	7,174,884
Excess (Deficit)	**(339,633)**	**(1,217,073)**	**12,268,382**	**10,703,225**

LEGAL UPDATE MEMORANDUM

TO: WVHA Board of Commissioners

DATE: March 12, 2019

FROM: Theodore W. Small, Jr.

RE: West Volusia Hospital Authority - Update for March 21, 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 February 12, 2019. This Memorandum will not reflect updates on matters resolved by a final vote of the Board and thereby already summarized in the February 21, 2019 Meeting Minutes.

I. Negotiations with UMR for TPA Services for Renewal Agreement. [*See new info. in italics and bold*] *[Refer back to Legal Update Memorandum dated 1/8/19 for additional background details.]*

After the February Board meeting, counsel notified UMR that the Board tabled a final decision on the proposed TPA agreement based on the hospitalization related absences of two Board members and also in hopes that further negotiation would result in a win-win resolution of the two legal objections as to the form of the agreement. Although further negotiations did result in a revision to clarify the meaning of Section 2.5, UMR once again refused to agree to any modification of Section 6.2 and A2 so that it would be responsible for its own negligence for overpayments in processing claims in the same manner as its predecessors, POMCO and HSI. UMR also confirmed that it would not agree to any modification that would clarify that WVHA's indemnification obligations would be limited to the same limits on damages as contained in the partial waiver of sovereign immunity in Section 768.28, Florida Statutes. Accordingly, except for a minor clarification in Section 2.5, the finally proposed agreement is not much changed from the last version which was included in the Board materials for the February meeting.

The below synopsis is mostly the same as described in my email dated 2/1/19. The Board Meeting packet contains the finally proposed TPA agreement from UMR. After I forwarded a copy of my 2/1/19 email to Mr. Jacobs in an effort to ensure that I had accurately represented UMR's positions, Mr. Jacobs advised that he had forwarded my email to UMR's legal department and corporate office and UMR did not desire to make any further modifications to that finally proposed TPA agreement.

As to form, I do NOT be recommend it for approval because UMR has refused to agree to accept financial responsibility for its own negligence in the same manner as have the past TPAs, POMCO and HSI. In addition, in Section 6.1(3), it is requiring WVHA to indemnify it against potential tortious misconduct of the affiliated agencies and their employees in a way that may void the limited waiver of sovereign immunity under Florida Statute, §768.28(6).

Instead, UMR in Section 6.2 and Section A2 has carved out its responsibility to pay claims accurately as one where it will not agree to indemnify or reimburse WVHA for "overpayments" unless WVHA can prove that UMR was "grossly negligent" in making the overpayment. UMR offered the following definition of what it means by gross negligence: A deliberate, conscious act or omission, which arises out of or results from UMR's intentional failure to perform obligations under this Agreement. Gross negligence is not the mere failure to exercise ordinary care. As their own definition makes clear, the gross negligence standard is very high and would insulate UMR from being responsible for the type of ordinary care (negligence) that the past TPA's were willing to be held accountable.

It is worth noting that UMR originally proposed that the same "gross negligence" standard apply to all of its services under the proposed agreement, but during the prior months of negotiations UMR was at least willing to indemnify WVHA and be held accountable for all other services (excepting overpayments) if it fails to meet a "Standard of Care" which is defined in the agreement: **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.

Counsel has repeatedly requested that this same Standard of Care also apply to overpayments and requested Mr. Jacobs take this request to the highest levels of the UMR contracting and legal teams. Mr. Jacobs has now communicated that this requested modification will not be accepted and the attached contract language is UMR's final proposal for the Board's consideration. Further, Mr. Jacobs plans to include the following explanation of UMR's position in its report to be included in the Board Meeting Materials:

> *We cannot agree to a standard of care for overpayments. The industry standard for claim payment accuracy is less than one hundred percent, thus it is recognized in this industry that total accuracy is not the standard; some mistakes are expected to occur. To move away from a gross negligence standard would create a situation where we may be expected to reimburse a customer for all overpayments, basically an error free standard, which is unattainable given the realities and complexities of this industry.*
>
> *We have a robust overpayment recovery process in place. We agree to diligently pursue overpayments, including utilizing our right to offset overpayments to network health care providers under our standard network provider contracts on behalf of our customers. (We can also do payment offsets with the WVHA funded agencies with permission from the WVHA Board)*
>
> *We also understand the customer's concern regarding accurate claims processing,*

which is why audits are provided for in the administrative service agreement.

UMR's explanation that it is insisting on the new "gross negligence" standard based on its inability to deliver 100% accuracy introduces an irrelevant topic and standard to divert the Board's attention from the undeniable fact that the new gross negligence standard is a substantial departure from the negligence standard within the current 2015 POMCO TPA agreement. In the currently effective TPA agreement, both sides agreed to indemnify the other for ordinary negligence even as they acknowledged that 100% accuracy was NOT possible. The following excerpt from the 2015 POMCO TPA agreement encapsulates that acknowledgement: "3(b)(4)*Clerical errors or normal variations in claim processing made without intent to defraud and absent negligence or willful misconduct are recognized in this Agreement as possible. When such errors or variations are made and discovered, the Client and POMCO shall work together in correcting, adjusting or otherwise making them right to the extent such is both possible and recoverable."* As indicated, the inability of a TPA to process claims with 100% accuracy is nothing new to WVHA's contracting with prior TPAs. What is new is UMR's attempt to justify a substantial lowering of its financial accountability, from the current requirement of delivering reasonably accurate results under the circumstances to one where it is only financially accountable when it intentionally or willfully delivers inaccurate results.

In practical terms, the WVHA Board has to decide whether to hire UMR to process claims and *trust* that UMR will have reasonable processes in place not to make overpayment mistakes, but accept that if UMR does make overpayment mistakes because it fails to exercise reasonable and ordinary care, WVHA would have to take financial responsibility for UMR's mistakes....unless UMR can recover the mistaken payment from the provider or, if not, WVHA can prove that UMR actually intended to make that overpayment. Put another simpler way, UMR won't take any financial responsibility for its own overpayment mistakes, but it will try to avoid making them and it will try to recover the funds using proprietary procedures.

In dollar terms, counsel requested DRT to provide the attached spreadsheet that indicates an example of just two UMR check runs (check dates 1/17/19 and 1/24/19) to pay claims. The range of **potential** overpayments in these two examples ranges from a check payment amount of $3.00 to $185,504.44. Counsel defers to DRT and UMR to provide the Board with information as to how often any actual overpayments have occurred in past experience with HS1, UMR f/k/a POMCO. Perhaps the potential for overpayments occurring is low enough that the Board is willing to approve the new gross negligence standard because past experience suggests it would have no practical financial impact in the future. But it is my duty as legal counsel to point out based on the range of check amounts indicated that the potential future financial impact is substantial if UMR does ever make an overpayment mistake and cannot recover that overpayment from the provider. It would be very difficult to prove intent or willfulness on the part of UMR in such an instance and so financial responsibility would most likely fall to WVHA and the taxpayers. The odds of WVHA having another Impact Healthcare experience may be slight and remote, but that possibility cannot be ignored in

evaluating this risk.

In addition to counsel's concerns about the form of the foregoing "gross negligence" standard of care, counsel has concerns about the lack of mutuality between Section 6.1 (WVHA's indemnification obligations) and Section 6.2 (UMR's indemnification obligations) and potential for limitless waiver of sovereign immunity. In a nutshell, UMR is insisting that it only provide indemnification for its material breach of the Contract and have no indemnification responsibility for its breach of third party agreement while, on the other hand, insisting that WVHA indemnify UMR for a third party breach, regardless of whether it is "material". As an example of such third party agreements, UMR has explained that it will need to enter into NDAs (non-disclosure agreements) with entities like The House Next Door to give them access to their web portals. Because these web portals would allow The House Next Door and others to have access to what UMR considers proprietary information, UMR is requiring WVHA to indemnify UMR if The House Next Door does not follow each and every technical or substantive requirement of such NDA agreements.

At this juncture, counsel is not familiar enough with the web portal content and the potential for theft or misuse (by The House Next Door) of what UMR considers proprietary information to predict what could be the practical impact of the indemnity obligation under Section 6.1(3). However, counsel is obligated to make sure the Board is aware of this potential liability and note UMR's insistence, for unexplained reasons, on a "breach" standard for triggering this indemnity obligation, as compared to the "material breach" trigger in the rest of Section 6.1 and 6.2.

It is also important for counsel to emphasize that the usual practice for most governmental entities is to refuse to indemnity vendors for the potential tortious misconduct by third parties. The rationale for such refusal is that usually governmental entities only have limited exposure for alleged torts because of the limited waiver of their sovereign immunity under Chapter 768.28(6). But the Florida Supreme Court has recognized that if a governmental entity agrees to contractually indemnify a non-governmental entity for tortious misconduct by third parties, that contractual obligation could effectively void the limits of liability under Chapter 768.28(6) and render the governmental entity responsible for an unlimited amount of tort damages. In the current 2015 POMCO TPA agreement, the reciprocal indemnity provision does not make WVHA responsible for tortious or other misconduct of third parties. But in the proposed new Contract, UMR is insisting that WVHA take on such liability which could render WVHA responsible for an unlimited amount of tort damages if, for example, a rogue employee of The House Next Door (or any other entity that UMR requires to sign an NDA) discloses PHI or steals UMR's trade secrets. WVHA is effectively being asked to become its brother's/sister's keeper with unpredictable exposure to unlimited liability that could void the limits under Chapter 768.28(6).

For all these reasons, counsel cannot recommend as to form UMR's finally proposed TPA Contract. Counsel is NOT recommending that the Board disapprove the proposed Contract

because all these matters are ultimately matters committed to the Board's discretion based on its business judgment as to how great are the risks of unrecoverable overpayments (particularly in light of recently reported POMCO billing $578,359.20 mistake), tortious misconduct that would trigger indemnity obligations and liability (to include attorneys' fees and costs) that would exceed the limits under Chapter 768.28(6), which should be balanced against its alternative TPA and contract options and potential interruption to Health Card member care.

As the Board considers the potential impact of not approving the proposed UMR TPA contract, the currently effective POMCO agreement, which was automatically renewed when neither party terminated it prior to its renewal date, provides in Section 5(b)(2) that the "TPA may terminate this Agreement without cause, and for any reason, upon 120 days written notice to Client". In effect, WVHA would have approximately 4 months from the date UMR notifies it of an intention to terminate the current TPA Agreement, to transition these services to an alternative TPA before Health Card members should experience interruptions of their care.

II. Discussions with EMPros Re: Restructuring Nature of Primary Care Physicians Indigent Hospital Patient Program Reimbursement Agreement (2006), as amended. [*See new info. in italics and bold*]

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. Duva, 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. *Ms. France contacted counsel Feburary 11, 2019 with some preliminary follow-up information which EMPros intends to finalize into a PowerPoint presentation for the Board's consideration at the upcoming March 21, 2019 Regular Meeting. Counsel responded to Ms. France with the following suggestions for EMPros finalizing their presentation to the Board:*

From: Ted Small [mailto:tsmall@businessemploymentlawyer.com]
Sent: Thursday, February 28, 2019 6:31 PM
To: 'Maureen France' <maureenfrance@gmail.com>
Subject: FW: WVHA Request

Hi Maureen, I have reviewed what you forwarded from Dr. Duva and compared it to what was expecting based on our December 11th discussion.
Overall, what you forwarded strikes me as back to the type of advocacy in the initial correspondence and public comments from EMPros where there is an explicit or implicit suggestion to the public that EMPros has been paid less than what it deserved for 20 years by WVHA, which has been grossly underfunding its indigent care obligations for ER care at both hospitals. That suggestion is simply not accurate since any underpayment to EMPros occurred as a result of agreements between EMPros and the hospitals for all these years. Until EMPros first learned that it was a subcontractor to contracts between the hospitals and WVHA and then brought the matter to the attention of WVHA late in 2018, EMPros and WVHA had no privity of contract and no knowledge of each other. Any responsibility for what you were paid in the past is between EMPros and the hospitals and the suggestion in this latest cover letter and chart that WVHA owes EMPros some consideration for its past underpayment by the hospitals is inappropriate and I suggest it be rewritten.

Next, I was left with the impression from our December 11th discussion that EMPros was going to gather data and information that would allow the Board to become informed about its discretion to select from a number of alternative funding arrangements if it elects to exercise that discretion and continue some level of funding for ER physician services. Please note again that it is the Adventist-owned and operated hospitals, not WVHA, that became obligated to provide care in the ERs once the hospitals took over ownership of those facilities in 2000. If the WVHA Board elects to reimburse for ER physician services for qualified indigent patients at those Adventist-owned facilities, it will not be based on any statutory obligation but instead based upon a negotiated contract. The data in the Excel spreadsheet you forwarded is mostly looking backward at what the hospitals haven't been paid in the past instead of looking *out of that past box* at what is fair in the marketplace based on what EMPros *should* reasonable

expect to be paid using a comparison of what it or other ER physicians are actually paid to provide care in communities with similar costs of living and care factors. For example, the data you forwarded reads more like advocacy that EMPros be moved immediately to receiving Medicare rates from WVHA from what it has been willing to accept as payment from the hospitals for nearly two decades. That WVHA had a 17.5 million dollar budget is not relevant to this negotiation any more than the total budget of Adventist Health Systems during past negotiations of the contract between EMPros and the hospitals. Similarly, it is advocacy for Medicare rates in your chart where you only present columns indicating comparisons of past payment with the Medicare rates without doing a chart showing similar comparisons for Medicaid rates, or rates that EMPros or some similar group is actually being paid for ER physician services in comparable communities. At a meeting, we discussed some source of dataset (which I believe involved United Health care) which would allow the Board to consider how any proposed adjustment to rates compared with state or national standard for rates of reimbursement that ER physicians are actually receiving for similar services. It doesn't strike me as very persuasive to look only at published governmental rates when EMPros cannot deny that it has privately contracted for nearly 20 years for a much lower rate with the hospitals. The WVHA board would need to question why should it agree to contract for such a monumental increase in rates when it can elect to do nothing and leave this cost exactly where the federal government has placed it, as an unfunded mandate on Adventist as the current owner and operator of the hospitals. I also note that missing in this proposed presentation is any discussion about creative flat rate or maximum cost pricing alternatives, which we discussed as an option that the WVHA would be presented for consideration.

In sum, I think the materials you forwarded should be reworked so that the conversation is more about what is a fair and reasonable win-win way for WVHA to contract directly with EMPros and thereby reimburse EMPros for at least some of its costs to provide quality physician services to indigent residents who present at the Adventist owned and operated hospitals, and a lot less about an indictment of WVHA for past underpayments which were totally a matter between EMPros and the hospitals. I don't think Board members will appreciate the suggestion that they haven't been paying what they should have been paying when they were at all times paying exactly what the hospitals requested each year on these contracts. After removing that false suggestion, the presentation should reflect a range of options and data to support a solution that is justified by what is actually going on in the marketplace rather than simply charting based on published governmental rates which were clearly ignored for decades by two private contracting parties.

For further clarification of what the WVHA Board has been told to expect, see below excerpt from my January legal update summarizing our December 11th meeting: [excerpt omitted here but included in actual email]

III. Downtown DeLand CRA: Notice of Amendment to Extend CRA Expiration from September 30, 2025 to December 31, 2036. [*See new info. in italics and bold*]

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.

As directed, counsel has followed up with Attorney Elkind and some CRA Members/Commissioners in an effort to get a better sense of how best to structure a request from WVHA for an exemption from future levies to support the redevelopment plans of the Downtown DeLand CRA. To avoid violating the Sunshine Law by publicly disclosing the positions of public officials on an issue likely to come before the DeLand City Commission and/or the Downtown DeLand CRA, counsel will not identify or describe in this public record the substance of any of those conversations. Instead, suffice it to say that counsel was left with the impression that although the City/CRA is open to listening to a request, it will be difficult to obtain a majority vote in favor of even a limited exemption from levies during the extended 2025 to 2036 time period; that WVHA will likely undermine its chances of getting such a majority vote if it asks for an exemption to start immediately and thereby leave the Downtown CRA and City without sufficient time to plan for the loss of roughly $100,000 in annual revenue; and that WVHA will likely undermine its chances of getting a majority to vote in favor of the limited exemption if it also plans to seek an exemption from the Springhill CRA. The City is particularly sensitive about doing anything that would potentially open the door to a reduction in funding for the Springhill CRA, which has always had difficulty funding its redevelopment plan and is now facing even more difficulties because several nursing homes are in that area are restructuring as tax exempt entities. The strength of a request for a limited exemption from the levies of only the Downtown DeLand CRA for the now extended 2025 to 2016 time period, is that it can be viewed as a reasonable and narrowly tailored reaction to the City/CRA's "surprise" decision to extend its existence beyond what WVHA expected. Further, WVHA would not be viewed as opening the door for other exemptions because of the recent State legislation which exempts hospital districts from new CRAs. If WVHA asks for

something immediate regarding Downtown DeLand and then asks for exemption from Spring Hill as well, the City/CRA may be less open to granting any exemption at all.

After initially drafting correspondence to the City Attorney on my own letterhead, it occurred to me that the more appropriate format is for the City to receive correspondence directly from the Board. Below is a draft of such correspondence for the Board's consideration and approval for execution by Chair Craig:

March 25, 2019

BY US Mail and E-mail (pleusm@DeLand.org)

Michael Pleus, DeLand City Manager
120 South Florida Avenue
DeLand, FL 32720

RE: WVHA Request for Exemption from Extended Time Period on Downtown DeLand CRA Pursuant to Section 163.387(2)(c)(7) & (d)(1), Florida Statutes

Dear Mr. Pleus:
I am writing in my capacity as Chair of the Board of Commissioners for the West Volusia Hospital Authority, an independent special tax district in Volusia County, Florida (the "Authority"). This letter is submitted in response to notice that was written by Assistant Manager Mike Grebosz on December 21, 2018 and delivered over the holidays regarding your public hearing on January 7, 2019 concerning a vote to extend the Downtown DeLand CRA until December 31, 2036.

The Authority is hereby requesting a limited exemption pursuant to Section 163.387(2)(c)(7) & (d)(1), Florida Statutes (and any other applicable provision of law) from the obligation to pay incremental assessments to fund the Downtown DeLand CRA from September 30, 2025 to December 31, 2036 ("Extension Period"), the eleven year period that the Downtown CRA and the City Commission voted to extend that CRA's duration. The bases for the Authority's request are as follows:

1. ***State Policy Now Recognizes Hospital Districts As Deserving Exemption.*** As a matter of public policy, the State has recognized that hospital districts which are special districts should be treated specially and should not have their funding "taxed" to fund redevelopment activities for any CRA created after July 1, 2016. *See* Section 163.387(2)(c)(7). It is acknowledged that the vote to extend was not

the same as a vote to create a new CRA, but the public policy embodied in this newly created special exemption applies the same.

2. *State Policy Has Always Recognized Special Districts That Collect Only Ad Volorem Tax Revenue As Deserving Exemption.* The Authority was "a special district for which the sole available source of revenue the district has the authority to levy is ad valorem taxes" at the time that the City Commission voted to approve the Extension Period. Cf. Section 163.387(2)(c)(2) (exemption automatic for special districts whose only source of revenue is ad valorem taxes at the time a CRA is created). It is acknowledged that the public policy inherent in this exemption of not having one taxing entity levy ad volorem taxes merely to benefit another entity with different purposes did not apply to WVHA at the time the Downtown DeLand CRA was created because in 1985, WVHA was operating hospital facilities. However, at all times following its sale of the hospitals in 2000, WVHA's sole source of revenue has been and is ad volorem taxes. Therefore, the public policy underlying this exemption also applies to WVHA concerning the subject Extension Period.
3. *The Authority Has Consistently Paid Downtown DeLand CRA Even Without Any Special Projects Being Included in Plan to Benefit The Authority.* The Authority has faithfully paid approximately _____ to support the projects of the Downtown DeLand CRA since its creation in 1985. This consistent funding has been provided even without any special projects to benefit WVHA being included within the approved redevelopment plan of the Downtown DeLand CRA. Cf. Section 163.387(2)(d)(2)(d). It is noteworthy that nearly a decade ago WVHA decided to continue funding the CRA despite the strong public policy arguments that would have supported its requesting an exemption. The Authority made this choice not to ask in part to avoid any disruption of the City's preexisting debt obligations or redevelopment plans. But this decision to continue was based on an expectation that this funding obligation would terminate on the original, September 30, 2025 expiration date. WVHA respectfully requests that the City develop plans and funding sources for the Extension Period that do not include WVHA. WVHA should not be forced to continue levying taxes to support these extended redevelopment plans when taxpayers have a right to reasonably expect that any millage levied by the Authority will be in furtherance of its statutorily authorized purpose of funding health care or access to health care.
4. *The Authority Is Asking Only for this Limited Exemption For The Specified Extension Period and Does Not Plan to Seek Any Further Exemption From the Downtown DeLand CRA or the Springhill CRA.* The Authority is mindful that the redevelopment planning and budgeting process for community redevelopment agencies is a long term process. Accordingly, WVHA will refrain from requesting that the

City Commission to exempt it from continuing to pay its incremental assessments to fund the previously established plans for the Downtown DeLand (through September 30, 2025) and Springhill CRAs.

Please distribute this letter to members of the City Commission and the Downtown DeLand CRA and let us know what additional information or action would be required from WVHA in order to have this request for exemption considered and, respectfully we ask, approved. Feel free to contact us or our attorney, Ted Small (386-740-0787), regarding any questions concerning the Authority's position.

Sincerely,
West Volusia Hospital Authority

By:

Chair, Judith L. Craig

IV. **WVHA as Plaintiff in Federal Multidistrict Litigation for National Prescription Opiate Litigation, James Vickaryous, Managing Partner of Vickaryous Law Firm.**

Counsel talked preliminarily with Jim Vickaryous, the Managing Partner of the Vickaryous Law Firm about WVHA retaining his law firm to represent WVHA on a contingency basis and file a lawsuit on behalf of WVHA in the federal multidistrict litigation for national prescription opiate litigation. Attorney Vickaryous plans to present a formal proposal to explain the details, but in a nutshell the proposed representation would offer WVHA a seat at the table among many other governmental and private entities around the nation that are suing pharmaceutical companies. These lawsuits are seeking to recover damages related to the substantial health care and prescription costs that have been paid to treat residents who became addicted to opioids. As of this writing, counsel has not yet received a draft of the proposed retainer agreement or the presentation materials. Attorney Vickaryous has indicated in an introductory call that if desired, WVHA would become one of several Florida based local government clients which his firm would represent. The contingency basis of the representation would provide that the Vickaryous Law Firm would be paid 20% of any net recovery after costs and WVHA would keep the remaining 80%. Attorney Vickaryous believes that it would be important to get WVHA's lawsuit on file as soon as practicable before settlement talks begin and conclude concerning a Tier 1 lawsuit that is scheduled for trial in Ohio during October, 2019. Attorney Vickaryous believes that the defendants in that lawsuit may want to negotiate a global settlement of all pending lawsuits and it would be advantageous for WVHA to have a seat at that table, particularly in light of the substantial annual budget expenses being paid to SMA and for prescriptions that are directly related to the opioid epidemic. Counsel expects to receive and review the details prior to the March meeting and have a recommendation as to the form of the retainer agreement at that time. As an overall matter, the proposal sounds like a potential opportunity for WVHA to recoup

substantial taxpayer dollars, but it may take some time before any recovery is obtained.

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 generally 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. 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.