

**SUMMARY OF MATERIAL MODIFICATIONS**  
**To the Summary Plan Description for**  
**Pinellas County Board of County Commissioners**  
**Effective January 1, 2011**

A Summary Plan Description (SPD) was published effective January 1, 2010. The following are modifications and clarifications that are effective January 1, 2011 unless otherwise stated. These modifications and clarifications are intended as a summary to supplement the SPD. It is important that you keep this summary with your SPD since this material plus the SPD comprise your complete SPD.

In the event of any discrepancy between this Summary of Material Modifications (SMM) and the SPD, the provisions of this SMM shall govern.

Section 2: Introduction	
Under Heading:	The Following Should be Noted:
Eligibility	<p>Replace the second paragraph with the following.</p> <p>Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:</p> <ul style="list-style-type: none"> <li>■ your Spouse, as defined in Section 14, Glossary;</li> <li>■ your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or</li> <li>■ an unmarried child age 26 or over who is or becomes disabled and dependent upon you.</li> </ul> <p>In the event that the Subscriber has a Dependent who meets the following requirements, extended coverage is available for that Dependent up to the age of 30. Contact your Enrolling Group for details. To be eligible for extended coverage, a Dependent must satisfy the following:</p> <ul style="list-style-type: none"> <li>■ Is unmarried and does not have dependent of his or her own;</li> <li>■ Is a resident of Florida or a Student, and</li> <li>■ Does not have coverage as a named subscriber, insured, enrollee or covered person under any other group, blanket or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.</li> </ul> <p>If such a Dependent's coverage is terminated after the</p>

<b>Section 2: Introduction</b>	
<b>Under Heading:</b>	<b>The Following Should be Noted:</b>
	<p>end of the calendar year in which the Dependent reached age 26, the child is not eligible to be covered under the Policy unless the Dependent was continuously covered by Creditable Coverage without a gap in coverage of more than 63 days.</p> <p>A child who is covered under extended coverage provisions set forth above ceases to be eligible as a Dependent on the last day of the calendar year following the child's attainment of the limiting age or when the child no longer meets the requirements.</p> <p>To be eligible for coverage under the Plan, a Dependent must reside within the United States.</p> <p><b>Note:</b> Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.</p> <p>A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, <i>Other Important Information</i>.</p>
<b>Changing Your Coverage</b>	<p><b>Remove the following bullet from the list.</b></p> <ul style="list-style-type: none"> <li>■ you or your eligible Dependent incurs a claim that would exceed a lifetime limit on all benefits under the elected health care option through Pinellas County Board of County Commissioners;</li> </ul>
<b>Dependent Child Special Open Enrollment Period</b>	<p><b>Add the following language at the end of the section immediately after the Changing Your Coverage section.</b></p> <p><b>Dependent Child Special Open Enrollment Period</b></p> <p>On or before the first day of the plan year beginning on or after September 23, 2010, the Plan will provide a 30 day dependent child special open enrollment period for Dependent children who have not yet reached the limiting age. During this dependent child special open enrollment period, Participants who are adding a Dependent child and who have a choice of coverage</p>

<b>Section 2: Introduction</b>	
<b>Under Heading:</b>	<b>The Following Should be Noted:</b>
	<p>options will be allowed to change options.</p> <p>Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if Human Resources receives your properly completed enrollment form and any required contribution for coverage within 31 days of the date the Dependent becomes eligible to enroll under this dependent child special open enrollment period.</p>

<b>Section 3: How The Plan Works</b>	
<b>Under Heading:</b>	<b>The Following Should be Noted:</b>
<b>Lifetime Maximum Benefit</b>	<b>Remove the heading and paragraph regarding lifetime maximums in its entirety.</b>
<b>How the Plan Works – Example</b>	<b>Remove all references to Lifetime Maximum Benefit from the example.</b>

<b>Section 5: Plan Highlights</b>		
<b>Replace the first paragraph with the following.</b>		
The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.		
<b>Replace the Lifetime Maximum Benefit row with the following.</b>		
<b>Plan Features</b>	<b>Network</b>	
<b>Lifetime Maximum Benefit<sup>3</sup></b> There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	
<b>Add the following footnote to the bottom of the first table.</b>		
<sup>3</sup> Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.		
<b>Covered Health Services<sup>1</sup></b>	<b>Percentage of Eligible Expenses Payable by the Plan:</b>	
	<b>Network</b>	<b>Non-Network</b>
<b>Preventive Care Services</b>	100%	

<b>Section 6: Additional Coverage Details</b>	
<b>Under Heading:</b>	<b>The Following Should be Noted:</b>
<b>Preventive Care Services</b>	<p><b>Replace the “Preventive Care Services” benefit category with the following.</b></p> <p><b>Preventive Care Services</b></p> <p>Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital 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:</p> <ul style="list-style-type: none"> <li>■ 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;</li> <li>■ immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;</li> <li>■ 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</li> <li>■ with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul>

<b>Section 8: Exclusions</b>	
<b>Under Heading:</b>	<b>The Following Should be Noted:</b>
<b>Preexisting Conditions</b>	<p><b>Replace the exclusions with the following.</b></p> <p>1. Benefits for the treatment of a Preexisting Condition are excluded unless you have had Continuous Creditable Coverage for 12 months. Preexisting Condition is defined in Section 14, Glossary.</p> <p>This exclusion applies to Dependents only and does not apply to Covered Persons under age 19.</p>

<b>Section 9: Claims Procedures</b>	
<b>Under Heading:</b>	<b>The Following Should be Noted:</b>
<b>How to Appeal a Denied Claim</b>	<p><b>Replace the first paragraph with the following.</b></p> <p>If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:</p> <ul style="list-style-type: none"> <li>■ the patient's name and ID number as shown on the ID card;</li> <li>■ the provider's name;</li> <li>■ the date of medical service;</li> <li>■ the reason you disagree with the denial; and</li> <li>■ any documentation or other written information to support your request.</li> </ul>
<b>External Review Program</b>	<p><b>Add the following language immediately following the section titled 'Review of an Appeal'. This replaces the existing shaded box titled 'Voluntary External Review Program'.</b></p> <p><b>External Review Program</b></p> <p>If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:</p> <ul style="list-style-type: none"> <li>■ clinical reasons;</li> <li>■ the exclusions for Experimental or Investigational Services or Unproven Services; or</li> <li>■ as otherwise required by applicable law.</li> </ul> <p>This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if Pinellas County Board of County Commissioners fails to respond to your appeal within the time lines stated below.</p> <p>You may request an independent review of the adverse benefit determination. Neither you nor Pinellas County Board of</p>

<b>Section 9: Claims Procedures</b>	
<b>Under Heading:</b>	<b>The Following Should be Noted:</b>
	<p>County Commissioners will have an opportunity to meet with the reviewer or otherwise participate in the reviewer’s decision.</p> <p>All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. You, your treating Physician or an authorized designated representative may request an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card.</p> <p>The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The Independent Review Organization (IRO) has been contracted by UnitedHealthcare and has no material affiliation or interest with UnitedHealthcare or Pinellas County Board of County Commissioners. UnitedHealthcare will choose the IRO based on a rotating list of approved IROs.</p> <p>In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO. Within applicable timeframes of UnitedHealthcare’s receipt of a request for independent review, the request will be forwarded to the IRO, together with:</p> <ul style="list-style-type: none"> <li>■ all relevant medical records;</li> <li>■ all other documents relied upon by Pinellas County Board of County Commissioners in making a decision on the case; and</li> <li>■ all other information or evidence that you or your Physician has already submitted to Pinellas County Board of County Commissioners.</li> </ul> <p>If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and UnitedHealthcare will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.</p> <p>The reviewer’s decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and Pinellas County Board of County Commissioners with the reviewer’s decision, a description of the qualifications of</p>

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	<p>the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.</p> <p>If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.</p> <p>You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.</p>														
<b>Timing of Appeals Determinations</b>	<p><b>Replace the table that describes the timeframes for appealing an Urgent Care Request.</b></p> <p>The tables below describe the time frames which you and UnitedHealthcare are required to follow.</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th colspan="2" style="text-align: center;"><b>Urgent Care Request for Benefits*</b></th> </tr> <tr> <th style="text-align: center;"><b>Type of Request for Benefits or Appeal</b></th> <th style="text-align: center;"><b>Timing</b></th> </tr> </thead> <tbody> <tr> <td>If your request for Benefits is incomplete, UnitedHealthcare must notify you within:</td> <td style="text-align: center;"><b>24 hours</b></td> </tr> <tr> <td>You must then provide completed request for Benefits to UnitedHealthcare within:</td> <td style="text-align: center;"><b>48 hours</b> after receiving notice of additional information required</td> </tr> <tr> <td>UnitedHealthcare must notify you of the benefit determination within:</td> <td style="text-align: center;"><b>24 hours</b></td> </tr> <tr> <td>If UnitedHealthcare denies your request for Benefits, you must appeal the adverse benefit determination no later than:</td> <td style="text-align: center;"><b>180 days</b> after receiving the adverse benefit determination</td> </tr> <tr> <td>UnitedHealthcare must notify you of the appeal decision within:</td> <td style="text-align: center;"><b>72 hours</b> after receiving the appeal</td> </tr> </tbody> </table> <p>*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.</p>	<b>Urgent Care Request for Benefits*</b>		<b>Type of Request for Benefits or Appeal</b>	<b>Timing</b>	If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	<b>24 hours</b>	You must then provide completed request for Benefits to UnitedHealthcare within:	<b>48 hours</b> after receiving notice of additional information required	UnitedHealthcare must notify you of the benefit determination within:	<b>24 hours</b>	If UnitedHealthcare denies your request for Benefits, you must appeal the adverse benefit determination no later than:	<b>180 days</b> after receiving the adverse benefit determination	UnitedHealthcare must notify you of the appeal decision within:	<b>72 hours</b> after receiving the appeal
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<b>Section 9: Claims Procedures</b>	
<b>Under Heading:</b>	<b>The Following Should be Noted:</b>
<b>Concurrent Care Claims</b>	<p>Replace the language in its entirety with the following.</p> <p><b><i>Concurrent Care Claims</i></b></p> <p>If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.</p> <p>If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.</p>

<b>Section 12: When Coverage Ends</b>	
<b>Under Heading:</b>	<b>The Following Should be Noted:</b>
<b>Other Events Ending Your Coverage</b>	<p>Remove the following language from the section.</p> <p>The Plan will provide written notice to you that your coverage has ended if any of the following occur:</p> <ul style="list-style-type: none"> <li>■ you permit an unauthorized person to use your ID card or you use another person's ID card;</li> <li>■ you knowingly give UnitedHealthcare false material information including, but not limited to, false information relating to another person's eligibility or status as a Dependent;</li> <li>■ you commit an act of physical or verbal abuse that imposes a threat to Pinellas County Board of County Commissioner's staff, UnitedHealthcare's staff, a provider or another Covered Person; or</li> <li>■ you violate any terms of the Plan.</li> </ul> <p>Add the following language under a new heading entitled "Other Events Ending Your Coverage":</p> <p><b><i>Other Events Ending Your Coverage</i></b></p> <p>The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:</p> <ul style="list-style-type: none"> <li>■ you commit an act, practice, or omission that constituted</li> </ul>

	<p>fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; or</p> <ul style="list-style-type: none"> <li>■ you commit an act of physical or verbal abuse that imposes a threat to Pinellas County Board of County Commissioner's staff, UnitedHealthcare's staff, a provider or another Covered Person.</li> </ul>
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<b>Section 14: Glossary</b>	
<b>Under Heading:</b>	<b>The Following Should be Noted:</b>
	<p><b>Remove the following definition</b></p> <p><b>Lifetime Maximum Benefit</b> – the most the Plan will pay for Benefits during the entire period you are enrolled in this Plan or any other medical plan offered by Pinellas County Board of County Commissioner. The Lifetime Maximum Benefit is shown in the first table in Section 5, Plan Highlights.</p>

<b>Section 15: IMPORTANT ADMINISTRATIVE INFORMATION</b>	
<b>Under Heading:</b>	<b>The Following Should be Noted:</b>
<b>Additional Plan Description</b>	<p><b>Replace the Claims Administrator's address with the following.</b></p> <p>UnitedHealthcare Insurance Company                      185 Asylum Street                      Hartford, CT 06103-3408</p>

<b>ATTACHMENT I – HEALTH CARE REFORM NOTICES</b>	
<b>Under Heading:</b>	<b>The Following Should be Noted:</b>
	<p><b>Add the following as a new section immediately after the section entitled “Important Administrative Information”.</b></p> <p><b>Patient Protection and Affordable Care Act (“PPACA”)</b></p> <p><i><b>Patient Protection Notices</b></i></p> <p>The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator’s network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.</p> <p>For children, you may designate a pediatrician as the primary care provider.</p> <p>You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator’s network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.</p>

<b>Entire SPD</b>
<b>The Following Should be Noted:</b>
Remove all references to Annual Maximum Benefit.

Contract Number: 214279  
Set Number: 011  
Document ID: 50114923