

**Minutes
Tri-County Retreat
Gallup Organization, Omaha, NE
Tuesday, November 15, 2004
9:00 A.M.**

Lancaster County

Bob Workman, Commissioner
Ray Stevens, Commissioner
Bernie Heier, Commissioner
Deb Schorr, Commissioner
Kerry Eagan, Chief Administrative Officer
Gwen Thorpe, Deputy Chief Administrative Officer
Patricia Owen, Chief Deputy County Clerk
Dave Kroeker, Budget & Fiscal Director

Douglas County

Mike Boyle, Commissioner
Clare Duda, Commissioner
Carol McBride Pirsch, Commissioner
Mary Ann Borgeson, Commissioner
Kyle Hutchings, Commissioner
Chris Rogers, Commissioner-Elect
Kathleen Kelly, Chief Administrative Officer
Patrick Bloomingdale, Assistant Administrator
Kristin Lynch, Administrative Specialist
Steve Walker, Fiscal Administrator
Kathleen Hall, Chief Deputy County Clerk
Mike Kelly, Lobbyist

Sarpy County

Inez Boyd, Commissioner
Aldona Doyle, Commissioner
Tim Schram, Commissioner
Brian Hanson, Fiscal Administrator
Deb Houghtaling, County Clerk
Mike Smith, County Attorney
Mark Wayne, Chief Administrative Officer
Fred Uhe, Deputy County Clerk/Lobbyist
Joe Kohout, Lobbyist

The Lancaster County Board met with representatives of Sarpy and Douglas Counties on November 15th, 2004 at the Gallup Organization, 1001 Gallup Drive, Omaha, Nebraska at 9:00 a.m. Also in attendance was Lt. Governor Dave Heineman, Larry Dix, Executive Director of the Nebraska Association of County Officials and Tom Shaw, reporter with the Omaha World Herald.

The following agenda items were discussed during this retreat, formal minutes were taken by the Douglas County Clerk's Office:

1. SCAN Board/Homeland Security issues with Lt. Governor Dave Heineman.
2. Emergency 911 Wireless Surcharge and County Representation
3. Reimbursement for State Prisoners
4. Medicaid Rate for Inmates/Crisis Center Patients
5. Juvenile Aid Program (LB640)
6. Offender Community Services Projects & Liability/Workman's Compensation
7. Diversion Programs
8. Jail Standards Board
9. Juvenile Offender Evaluations
10. Interim study on County Government
11. Behavioral Health Reform and Impacts
12. Bryan LGH Lawsuit
13. I-80 Corridor Meeting
14. LB 1083-Community Treatment and General Assistance Impacts
15. Medical and pharmaceutical costs
16. Employee Benefits
17. Budget Limits
18. County Ordinance Authority
19. Road Construction Financing
20. Storm Water Runoff Issues
21. Board of Equalization
22. State Supreme Court Legislative Priorities

The retreat was adjourned at 3:00 p.m.

Patricia Owen
Chief Deputy County Clerk

LB695 HISTORY

ibhist

LB695 funding began July, 1999 at \$35 per day

07/08/2004

	AMTS BILLED	Periods billed	AMTS COLLECTED	Periods paid	SHORTAGE	
FY00	\$348,915	7/99-5/00	\$348,915	7/99-5/00	\$0	
FY01	\$1,041,810	6/00-5/01	\$1,041,810	6/00-5/01	\$0	
FY02	\$1,012,410	6/01-5/02	\$972,850	7/01-5/02	\$39,560	6/01 unpaid; lack of funding
FY03	\$1,245,860	6/02-5/03	\$778,012	6/02-2/03, 6/01paid	\$467,848	6/01 paid; partial 2/03 & 3/03-5/03 unpaid, lack of funding
FY04	\$1,464,715	6/03-5/04	\$739,083	7/03-1/04 partial pd	\$725,632	6/03 unpaid; partial 1/04, unpaid 2/04 to 5/04
June, 04	\$128,975	6/04	\$0	6/04	\$128,975	6/04 unpaid, lack of funding

TOTAL LOSS TO 6/04 **\$1,362,015** Finalized Figures

In FY03, State began paying quarterly

FY03	BILLED	INMATE DAYS	PAID	UNPAID	
JUNE, 2002	\$55,335	1,581	\$55,335	\$0	(State considers FY02 appropriation)
JULY, 2002	\$111,930	3,198	\$111,930	\$0	
AUG, 2002	\$65,380	1,868	\$65,380	\$0	
SEPT, 2002	\$71,505	2,043	\$71,505	\$0	
OCT, 2002	\$114,205	3,263	\$114,205	\$0	
NOV, 2002	\$76,860	2,196	\$76,860	\$0	
DEC, 2002	\$81,795	2,337	\$81,795	\$0	
JAN, 2003	\$144,410	4,126	\$144,410	\$0	
FEB, 2003	\$65,485	1,871	\$17,032	\$48,453	Partial payment; lack of appropriation
MAR, 2003	\$168,350	4,810	\$0	\$168,350	
APR, 2003	\$163,450	4,670	\$0	\$163,450	
MAY, 2003	\$127,155	3,633	\$0	\$127,155	

\$1,245,860 **35,596** **\$738,452** **\$507,408** Actual funds owed to date

ACTUAL FY03 RATE PAID PER DAY **\$20.75**

ANTICIPATED FY04 ACTIVITY

FY04	BILLED	INMATE DAYS	PAID	UNPAID	
JUNE, 2003	\$114,905	3,283	\$0	\$114,905	(Bill & collect in following FY)
JULY, 2003	\$176,435	5,041	\$176,435	\$0	
AUG, 2003	\$94,290	2,694	\$94,290	\$0	
SEPT, 2003	\$143,185	4,091	\$143,185	\$0	
OCT, 2003	\$96,880	2,768	\$96,880	\$0	
NOV, 2003	\$101,815	2,909	\$101,780	\$35	
DEC, 2003	\$102,760	2,936	\$102,760	\$0	
State error-correction pending 3/26/2004				\$35	(\$35) Payment rec'd on Nov shortage
JAN, 2004	\$146,965	4,199	\$23,718	\$123,247	Partial payment-lack of appropriation
FEB, 2004	\$87,430	2,498	\$0	\$87,430	No funding
MAR, 2004	\$121,170	3,462	\$0	\$121,170	No funding
APR, 2004	\$144,620	4,132	\$0	\$144,620	No funding
MAY, 2004	\$134,260	3,836	\$0	\$134,260	No funding

\$1,464,715 **41,849** **\$739,083** **\$725,632**

ACTUAL FY04 RATE PAID PER DAY **\$17.66**

FY05 ACTIVITY

JUNE, 2004	\$128,975	3,685	\$0	\$128,975	No funding (FY04)
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TOTAL ANTICIPATED 2-YR ACTIVITY	INVOICED	# DAYS	ACTUAL PAYMTS	UNPAID	
	\$2,839,550	81,130	\$1,477,535	\$1,362,015	FOR FY03 AND FY04

AVG DAILY RATE PAID **\$18.21**
52.0% OF \$35 RATE ACTUALLY PAID

2005 LANCASTER COUNTY LEGISLATIVE PRIORITIES

1. **Mental Health System Reform**

Lancaster County will carefully monitor the implementation of 2004 Leg. Session LB 1083. While the State's transition to a community-based mental health system may result in more effective services at less cost, there is a risk the responsibility and cost of providing mental health services will be shifted to the counties. Specifically, the County is concerned about the impact of LB 1083 on the Community Mental Health Center, emergency protective custody services, general assistance, and the criminal justice system. Adequate funding for new and existing programs must be appropriated by the Legislature.
2. **2 Cent Gas Tax Increase for Road Construction**

The County supports the efforts of the City of Lincoln to increase funding for local road construction generated through a 2 cent increase to the gas tax. The County and City would share equally in the additional revenue and the funds could only be used for construction of new roads or major improvement of existing roads.
3. **Medicaid Rate for Inmates and Crisis Center Patients**

NEB. REV. STAT. §47-103 should be amended to provide for payment of inmate medical expenses at the Medicaid rate, and NEB. REV. STAT. §83-1020 should be amended to provide for payment of medical expenses for emergency protective custody patients at the Medicaid rate. Alternatively, NEB. REV. STAT. §77-202 could be amended to require tax exempt nonprofit health care organizations to provide medical services to persons in legal custody of political entities at the Medicaid rate.
4. **Amend Civil Service Statutes to Protect Employees Transferred from Other Governmental Entities**

When a governmental function is transferred from one governmental entity to another, transferred employees may lose seniority, pension vesting rights, health insurance, accumulated vacation, sick leave, and other benefits. In some cases transferred employees may be required to reapply for their position. The civil service statutes should be amended to give governmental entities the authority and flexibility to waive hiring requirements for these employees and to protect their accrued benefits.
5. **Other Priorities**
 - a. Administrative approval of final plats
 - b. Extend Board of Equalization period to August 10
 - c. Clarify authority to require building permits on farmstead residences
 - d. Ordinance authority for counties




Julie J Righter

11/08/04 02:16 PM

To: Steve D Hubka/Notes@Notes

cc:

Subject: Re: 911 Receipts 

Great - thanks!

Steve D Hubka

Steve D Hubka

11/08/2004 01:55
PM

To: Julie J Righter/Notes

cc:

Subject: 911 Receipts

Here is what I come up with by fiscal year with the quarters after the .75 cents took effect converted back to a .50 cent rate.

1999-2000 867,479

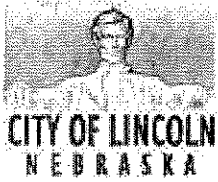
2000-2001 878,750

2000-2001 840,418

2002-2003 793,092

2003-2004 759,886

2004-2005 735,263 This is projected as if at .50 based on one quarters collections (ending 9/30/04). If the trend shown above were to continue, actual receipts for 2004-2005 would be slightly lower than shown here since every quarters receipts have been dropping.



**City of Lincoln
Personnel Department
Risk Management**

County Benefit Information

RETIREMENT PLAN:

Employee contributes 5.2% of annual salary and the County contributes \$1.50 for each \$1.00 of employee contribution.

HEALTH INSURANCE:

The County maintains a group health policy with the following contributions.

Single - County contributes 100% of the monthly premium.

2/4 Party - County contributes 85% of the monthly premium.

Family - County contributes 85% of the monthly premium.

For Deputy Sheriffs:

Single - County contributes 95% of the monthly premium.

2/4 Party - County contributes 80% of the monthly premium.

Family - County contributes 80% of the monthly premium.

For Correctional Officers:

Single - County contributes 100% of the monthly premium.

2/4 Party - County contributes 85% of the monthly premium.

Family - County contributes 85% of the monthly premium.

DENTAL INSURANCE:

75% of County Dental paid by County.

For Deputy Sheriffs:

Single - County contributes 100% of the monthly premium.

2/4 Party - County contributes 75% of the monthly premium.

Family - County contributes 75% of the monthly premium.

For Correctional Officers:

Single - County contributes 100% of the monthly premium.

2/4 Party - County contributes 85% of the monthly premium.

Family - County contributes 85% of the monthly premium.

LIFE INSURANCE:

\$20,000, \$30,000 or \$50,000 term life policy, depending on group, paid by County with option to buy \$100,000 additional employee coverage with dependent coverage available at employee cost.

DEFERRED COMPENSATION

Tax sheltered savings for retirement. \$12,000 maximum contribution for 2003 tax year.

FLEXIBLE EMPLOYEE BENEFIT ACCOUNT

Income Tax Savings. Three accounts available - premium account, dependent care and miscellaneous medical.

POST EMPLOYMENT HEALTH PLAN (PEHP)

Available for some County positions.

LONG TERM DISABILITY

COLLEGE SAVINGS PLAN

DIRECT DEPOSIT

LONG TERM CARE INSURANCE

BUS PASSPORTS

1/2 Price.

VACATION

Hours vary based upon length of service.

SICK LEAVE

Earn 13 days per year.

HOLIDAYS

10 regular & 3 noncumulative personal holidays per year.

Correctional Officers: 5 days and 60 holiday bank hours.

Deputy Sheriffs: 9 days and either 32 or 14 hours personnel holiday, depending on shift.

NOTE: Vacation, sick leave and holiday for part-time employees are prorated based on hours worked.

Must be regularly scheduled to work 20 hrs. or more per week to be eligible for health, dental and life insurance, and for retirement plan.

Eligible employees may elect health and dental coverage to begin first of the month following 90 days of employment. The employer contribution will begin at this point. If coverage elected earlier, employee pays 100% of the premium.

ASO Choice Plus *Plan 065*

Choice Plus plan gives you the freedom to see any Physician or other health care professional from the Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, your plan only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care.*

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care CoordinationSM services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

Choice Plus Benefits Summary

Types of Coverage

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Summary Plan Description that you will receive upon enrolling in the Plan.**

If this Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the Summary Plan Description shall prevail.

Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.

Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law.

Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician.

*Prior Notification is required for certain services.

Network Benefits / Copayment Amounts

Annual Deductible: \$250 per Covered Person per calendar year, not to exceed \$500 for all Covered Persons in a family.

Out-of-Pocket Maximum: \$500 per Covered Person per calendar year, not to exceed \$1,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the SPD.

Maximum Plan Benefit: \$2,000,000 per Covered Person.

Non-Network Benefits / Copayment Amounts

Annual Deductible: \$250 per Covered Person per calendar year, not to exceed \$500 for all Covered Persons in a family.

Out-of-Pocket Maximum: \$1,250 per Covered Person per calendar year, not to exceed \$2,500 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the SPD.

Maximum Plan Benefit: \$2,000,000 per Covered Person.

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
1. Ambulance Services - Emergency only	Ground Transportation: 10% of Eligible Expenses Air Transportation: 10% of Eligible Expenses	Same as Network Benefit
2. Dental Services - Accident only	*10% of Eligible Expenses *Prior notification is required before follow-up treatment begins.	*Same as Network Benefit *Prior notification is required before follow-up treatment begins.
3. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year.	10% of Eligible Expenses	*20% of Eligible Expenses *Prior notification is required when the cost is more than \$1,000
4. Emergency Health Services	\$100 per visit	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
5. Eye Examinations Refractive eye examinations are limited to one every other calendar year from a Network Provider.	\$15 per visit	20% of Eligible Expenses Eye Examinations for refractive errors are not covered.
6. Home Health Care Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	10% of Eligible Expenses	*20% of Eligible Expenses
7. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Plan.	10% of Eligible Expenses	*20% of Eligible Expenses
8. Hospital - Inpatient Stay	10% of Eligible Expenses	*20% of Eligible Expenses
9. Injections Received in a Physician's Office	\$15 per visit	20% per injection
10. Maternity Services	Same as 8, 11, 12 and 13 No Copayment applies to Physician office visits for prenatal care after the first visit.	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	10% of Eligible Expenses	20% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: 10% of Eligible Expenses For mammography testing: 10% of Eligible Expenses	20% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	10% of Eligible Expenses	20% of Eligible Expenses
Outpatient Therapeutic Treatments	10% of Eligible Expenses	20% of Eligible Expenses
12. Physician's Office Services	\$15 per visit. No Copayment applies when a Physician charge is not assessed.	20% of Eligible Expenses.
13. Professional Fees for Surgical and Medical Services	10% of Eligible Expenses	20% of Eligible Expenses
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to \$2,500 per calendar year.	10% of Eligible Expenses	20% of Eligible Expenses
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14

YOUR BENEFITS

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
16. Rehabilitation Services – Outpatient Therapy Network and Non-Network Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	\$15 per visit	20% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	10% of Eligible Expenses	*20% of Eligible Expenses
18. Transplantation Services	*10% of Eligible Expenses	*20% of Eligible Expenses Benefits are limited to \$30,000 per transplant.
19. Urgent Care Center Services	\$35 per visit	20% of Eligible Expenses
Additional Benefits		
Mental Health and Substance Abuse Services – Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 20 visits per calendar year.	\$15 per individual visit; \$10 per group visit.	20% of Eligible Expenses
Mental Health and Substance Abuse Services – Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 30 days per calendar year.	10% of Eligible Expenses	20% of Eligible Expenses
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to 24 visits per calendar year.	\$15 per visit	20% of Eligible Expenses
Dental Services – Hospital / Medical	Same as 11 and 13	Same as 11 and 13
Diabetes Treatment	10% of Eligible Expenses for equipment and supplies; \$15 per visit for diabetes self-management training.	20% of Eligible Expenses for equipment and supplies; \$30 per visit for diabetes self-management training. *Prior notification is required when the equipment cost is more than \$1,000
Mental Health Services – Serious Mental Health	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
Temporomandibular Joint Disorder (TMJ) Benefits are subject to a Maximum Policy Benefit of \$2,500.00	Same as 8, 11, 12, 13, 14 and 15	Same as 8, 11, 12, 13, 14 and 15
Pharmacy		
Retail Pharmacy (Up to a 31-day supply)	Tier 1 (Formally Generic) \$10 Tier 2 (Formally Brand) \$25 Tier 3 (Formally Non-Preferred Brand) \$40	Tier 1 (Formally Generic) \$10 Tier 2 (Formally Brand) \$25 Tier 3 (Formally Non-Preferred Brand) \$40
Mail Service Pharmacy (Up to a 90-day supply)	Tier 1 (Formally Generic) \$25 Tier 2 (Formally Brand) \$62.50 Tier 3 (Formally Non-Preferred Brand) \$100	Not Covered. Not Covered. Not Covered.
Diabetic Supplies	10% of Eligible Expenses	Not Covered.

Exclusions

ASO

Except as may be specifically provided in Section 1 of the Summary Plan Description (SPD) or through a Rider to the Plan, the following are not covered:

A. Alternative Treatments

Acupuncture; hypnosis; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the SPD for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the SPD.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclozocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the SPD.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the SPD (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments.

Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the SPD. Any solid-organ transplant that is performed as a treatment for cancer.

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the SPD.

O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services.

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the SPD.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.

In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring.

Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

This summary of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This plan may not cover all your health care expenses. Please refer to the Summary Plan Description for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Summary Plan Description, the Summary Plan Description prevails. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.

11/02/04 WLFA003 100-3513

UnitedHealthcare Plan 017

Pharmacy Management Program

UnitedHealthcare's pharmacy management program provides clinical pharmacy services that promote choice, accessibility and value. The program offers a broad network of pharmacies (more than 50,000 nationwide) to provide convenient access to medications.

While most pharmacies participate in our network, you should check first. Call your pharmacist or visit our online pharmacy service at www.myuhc.com. The online service offers you home delivery of prescriptions, ability to view personal benefit coverage, access health and well being information, and even location of network retail neighborhood pharmacies by zip code.

Copayment per Prescription Order or Refill

For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits. You are responsible for paying the lower of the applicable Copayment or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment or the mail order Pharmacy's Prescription Drug Cost.

Also note that some Prescription Drug Products require that you notify us in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven

	Generic Prescription Drug Product	Brand-name Prescription Drug Product on the Preferred Drug List*	Brand-name Prescription Drug Product not on the Preferred Drug List
Retail Network Pharmacy For up to a 31 day supply	\$10	\$25	\$40
Mail Service Network Pharmacy For up to a 90 day supply	\$25	\$62.50	\$100
Retail Non-Network Pharmacy For up to a 31 day supply	\$10	\$25	\$40

*Our Preferred Drug List includes those drugs available to you at the most affordable cost. It is one of the best ways to maximize your prescription drug benefits. The drug list, developed by physicians and pharmacists on our national Pharmacy and Therapeutics committee, includes a wide selection of generic and brand name prescription medications commonly prescribed by physicians. The Preferred Drug List is updated throughout the year. The most current version is available at our online pharmacy at www.myuhc.com.

LANCASTER COUNTY
HEALTH AND DENTAL INSURANCE MONTHLY RATES
EFFECTIVE JANUARY 1, 2005 THROUGH DECEMBER 31, 2005
FOR *AFSCME/*NON-REPRESENTED/UNCLASSIFIED

UNITED HEALTHCARE SELECTPLUS VALUE POS

	<u>SINGLE</u>	<u>2/4 PARTY</u>	<u>FAMILY</u>
FULL PREMIUM	\$459.22	\$1,033.26	\$1,377.64
COUNTY SHARE	<u>\$459.22</u>	<u>\$ 878.28</u>	<u>\$1,171.00</u>
*EMPLOYEE SHARE	\$ 0.00	\$ 154.98	\$ 206.64

AMERITAS DENTAL

	<u>SINGLE</u>	<u>2/4 PARTY</u>	<u>FAMILY</u>
FULL PREMIUM	\$ 23.46	\$ 52.98	\$ 82.49
COUNTY SHARE	<u>\$ 17.60</u>	<u>\$ 39.74</u>	<u>\$ 61.87</u>
*EMPLOYEE SHARE	\$ 5.86	\$ 13.24	\$ 20.62

EYEMED VISION CARE

	<u>SINGLE</u>	<u>2-PARTY</u>	<u>4-PARTY</u>	<u>FAMILY</u>
EMPLOYEE SHARE	\$ 8.38	\$ 15.92	\$ 16.76	\$ 25.14

There are four enrollment options available for health/dental/vision coverage. They are:

Single. Provides coverage for employee only.

Two-Party. Provides coverage for employee and spouse. This option does not provide coverage for children.

Four-Party. Provides coverage for employee and any number of eligible dependent children. This option does not provide coverage for a spouse.

Family. Provides coverage for employee, spouse, and any number of eligible dependent children.

* Must complete 90 days of employment before employee is eligible for County contribution.

LANCASTER COUNTY
HEALTH AND DENTAL INSURANCE MONTHLY RATES
EFFECTIVE JANUARY 1, 2005 THROUGH DECEMBER 31, 2005
FOR *CORRECTIONAL OFFICERS

UNITED HEALTHCARE SELECTPLUS VALUE POS

	<u>SINGLE</u>	<u>2/4 PARTY</u>	<u>FAMILY</u>
FULL PREMIUM	\$459.22	\$1,033.26	\$1,377.64
COUNTY SHARE	<u>\$459.22</u>	<u>\$ 878.28</u>	<u>\$1,171.00</u>
*EMPLOYEE SHARE	\$ 0.00	\$ 154.98	\$ 206.64

AMERITAS DENTAL

	<u>SINGLE</u>	<u>2/4 PARTY</u>	<u>FAMILY</u>
FULL PREMIUM	\$ 23.46	\$ 52.98	\$ 82.49
COUNTY SHARE	<u>\$ 23.46</u>	<u>\$ 45.03</u>	<u>\$ 70.12</u>
*EMPLOYEE SHARE	\$ 0.00	\$ 7.95	\$ 12.37

EYEMED VISION CARE

	<u>SINGLE</u>	<u>2-PARTY</u>	<u>4-PARTY</u>	<u>FAMILY</u>
EMPLOYEE SHARE	\$ 8.38	\$ 15.92	\$ 16.76	\$ 25.14

There are four enrollment options available for health/dental/vision coverage. They are:

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Two-Party. Provides coverage for employee and spouse. This option does not provide coverage for children.

Four-Party. Provides coverage for employee and any number of eligible dependent children. This option does not provide coverage for a spouse.

Family. Provides coverage for employee, spouse, and any number of eligible dependent children.

* Must complete 90 days of employment before employee is eligible for County contribution.

LANCASTER COUNTY
HEALTH AND DENTAL INSURANCE MONTHLY RATES
EFFECTIVE JANUARY 1, 2005 THROUGH DECEMBER 31, 2005
FOR DEPUTY SHERIFFS

UNITED HEALTHCARE SELECTPLUS VALUE POS

	<u>SINGLE</u>	<u>2/4 PARTY</u>	<u>FAMILY</u>
FULL PREMIUM	\$459.22	\$1,033.26	\$1,377.64
COUNTY SHARE	<u>\$436.26</u>	<u>\$ 878.28</u>	<u>\$1,171.00</u>
*EMPLOYEE SHARE	\$ 22.96	\$ 154.98	\$ 206.64

AMERITAS DENTAL

	<u>SINGLE</u>	<u>2/4 PARTY</u>	<u>FAMILY</u>
FULL PREMIUM	\$ 23.46	\$ 52.98	\$ 82.49
COUNTY SHARE	<u>\$ 23.46</u>	<u>\$ 39.74</u>	<u>\$ 61.87</u>
*EMPLOYEE SHARE	\$ 0.00	\$ 13.24	\$ 20.62

EYEMED VISION CARE

	<u>SINGLE</u>	<u>2-PARTY</u>	<u>4-PARTY</u>	<u>FAMILY</u>
EMPLOYEE SHARE	\$ 8.38	\$ 15.92	\$ 16.76	\$ 25.14

There are four enrollment options available for health/dental/vision coverage. They are:

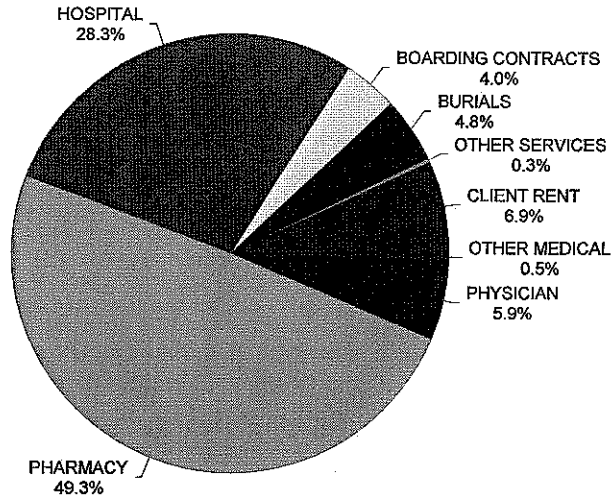
Single. Provides coverage for employee only.

Two-Party. Provides coverage for employee and spouse. This option does not provide coverage for children.

Four-Party. Provides coverage for employee and any number of eligible dependent children. This option does not provide coverage for a spouse.

Family. Provides coverage for employee, spouse, and any number of eligible dependent children.

G.A. CLIENT SERVICES BUDGET
2004-05 BUDGET



PERCENT OF FY 2004-05 REMAINING =66.67%

	FY02 EXPENDED	FY03 EXPENDED	6-30-04 EXPENDED	FY05 BUDGET	PER TABLE 10-31-04 EXPENDED	10-31-04 BALANCE	PERCENT REMAINING
CLIENT SERVICES:							
CLIENT RENT	125,532	171,645	160,265	170,000	51,151	118,849	69.91%
OTHER SERVICES	6,774	5,420	7,621	7,500	5,593	1,907	25.43%
BURIALS	123,499	103,368	116,732	120,000	40,348	79,652	66.38%
BOARDING CONTRACTS	16,458	37,958	129,959	100,000	44,733	55,267	55.27%
HOSPITAL	577,278	613,150	567,464	700,000	367,517	332,483	47.50%
PHARMACY	622,441	944,098	1,291,975	1,221,000	673,359	547,641	44.85%
PHYSICIAN	172,816	200,499	129,132	145,000	154,672	(9,672)	-6.67%
OTHER MEDICAL	26,824	18,517	7,710	11,700	14,342	(2,642)	-22.58%
SUBTOTAL	1,671,622	2,094,655	2,410,858	2,475,200	1,351,715	1,123,485	45.39%
RENT & ADMINISTRATION:							
G.A. CONTRACT	88,018	93,527	101,270	25,500	24,700	800	3.14%
FACILITY RENT	248,040	197,649	239,206	241,000	0	241,000	100.00%
LLCHD P.C. CONTRACT	136,680	203,105	244,383	258,500	0	258,500	100.00%
TOTAL G.A./MED	2,144,360	2,588,936	2,995,717	3,000,200	1,376,415	1,623,785	54.12%

PHARMACY REIMBURSEMENT YEAR TO 10-31-04 25,238
PHARMACY REIMBURSEMENT YEAR ENDED 6-30-04 TOTALS 97,713
PHARMACY REIMBURSEMENT YEAR ENDED 6-30-03 TOTALS 50,754
PHARMACY REIMBURSEMENT YEAR ENDED 6-30-02 TOTALS 48,082

IF CLIENT SERVICES CONTINUE AT THE PACE THEY HAVE FOR THE FIRST FOUR MONTHS WE WILL NEED TO APPROX 1,580,000 OF ADDITIONAL APPROPRIATIONS FOR THIS BUDGET.

FOUR MONTHS OF CLIENT SERVICES FY05

AVERAGE MONTHLY EXPENDITURE	337,929
	x 12
PROJECTED FY05 AT CURRENT PACE	4,055,148
AMOUNT BUDGETED	2,475,200
BUDGET SHORT	<u>1,579,948</u>

* It appears that we may be doing some catch up on past due bills, Spending at this rate will be hard on our FY05 budget and lower our fund balance adding an additional penny to our FY06 tax rate.

