HMO/POS Large Group Certificate of Coverage

Provided by:

Florida Hospital Care Advantage

Underwritten by Health First Commercial Plans

Headquarters
6450 US Highway 1,
Rockledge, FL 32955

Customer Service: 844-522-5279

PAYMENT DUE: BY THE FIRST DAY OF EACH MONTH FOR WHICH COVERAGE IS OFFERED
FLORIDA HOSPITAL CARE ADVANTAGE
UNDERWRITTEN BY HEALTH FIRST COMMERCIAL PLANS
6450 US Highway 1
Rockledge, Florida 32955

CERTIFICATE OF COVERAGE

Please call (844) 522-5279 for assistance regarding claims and information about coverage.

Employer Name:
Group Plan Number:
Group Plan Design:
Customer Service Number: Toll Free (844) 522-5279

In accordance with the terms of the Group Plan issued to the Large Employer, Health First Commercial Plans, Inc. d/b/a Florida Hospital Care Advantage, (hereinafter called the Health Plan) certifies that it will cover all eligible enrolled persons for the services described in this Certificate. This Certificate replaces any and all certificates and riders previously issued.

The Health Plan will provide the services described in this Certificate to Covered Employees and their Covered Dependents (hereinafter called “Insured” or “Covered Persons”), if any, on a direct-service basis. This means that the Health Plan arranges or contracts with Physicians, Hospitals, or other Providers of medical care and employs administrative personnel to directly provide, organize, and arrange for such service. The Health Plan agrees to use its best efforts to assure that its Providers render quality Health Care Services in conformity with accepted community medical standards. The Physicians, Hospitals and Providers of medical care are not the Health Plan’s agents, apparent agents or employees, nor is the Health Plan their agent, apparent agent or employee. Nothing contained in this Group Plan is intended to interfere with communication between the Insured and their Physicians, Hospitals, and Providers, and the Health Plan does not control the clinical judgment or treatment recommendation made by any Provider.

This Certificate describes the administrative details, services, provisions, and limitations of the Group Plan. The services outlined in this Certificate are effective only if a person is eligible for coverage, becomes covered, and remains covered in accordance with the terms of this plan.

Any changes in this Certificate must be approved by an officer of the company and endorsed on the Certificate or attached to it. Any verbal promise made by an officer or employee of the company, or any other person, including an agent, will not be binding on the company unless it is contained in writing in this Certificate or an endorsement to it.

CEO
Health First Commercial Plans, Inc. d/b/a Florida Hospital Care Advantage

FHCA LG HMO_POS CONTRACT (1_2016) R1215
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E. MICHELLE’S LAW

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RIDER(S)
I. INTRODUCTION TO YOUR CERTIFICATE OF COVERAGE

This Certificate of Coverage (Certificate) and other Contract documents describe your benefits, provisions of this Group Plan, as well as your rights and responsibilities under the Contract. We encourage you to read your Certificate and any attached riders and/or amendments carefully. If there is a conflict between this Certificate and any summaries or other materials provided to you by the Health Plan or the enrolling group, this Certificate shall prevail. Please refer to your Schedule of Benefits included in this Certificate to determine how much you have to pay for particular Health Care Services.

When reading your Certificate, please remember:

1. You should read this Certificate in its entirety in order to determine if a particular Health Care Service is covered.

2. The headings of sections contained in this Certificate are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.

3. References to "you" or "your" throughout refer to you as the Certificate Holder and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references which refer solely to you as the Certificate Holder or solely to your Covered Dependent(s) will be noted as such.

4. References to "we", "us", and "our" throughout refer to Health First Commercial Plans, Inc. d/b/a Florida Hospital Care Advantage. We may also refer to ourselves as the Health Plan.

5. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the "Definitions" section or defined within the particular section where it is used.

ENTIRE CONTRACT CHANGES

This policy, with the application and attached papers, is the entire contract between the Insured and the insurer. No change in this policy will be effective until approved by an officer of the insurer. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

II. ADMINISTRATIVE PROVISIONS

This section provides important information on the administration of this Group Plan, explaining:

1. Who is eligible for benefits under this Group Plan, when coverage becomes effective, when coverage terminates and what the Insured can do to continue coverage upon termination;

2. How this Group Plan will relate to other plans under which the Insured have coverage or other situations where payment is made for the services covered under this Group Plan; and
3. How the Insured can Appeal to the Health Plan upon disagreement of coverage-based decisions.

A. ELIGIBILITY UNDER THIS GROUP PLAN

Because this coverage is group coverage, eligibility for coverage is tied to the individual's relationship with the employer that establishes this Group Plan. To be eligible for coverage under this Group Plan, an individual must be either:

1. An Eligible Employee of the Employer. An **Eligible Employee** is an individual who:
   
a. works for the employer on a full-time basis or part-time basis as defined by the Large Employer,

   b. is approved by the Health Plan, and

   c. lives or works in the Service Area, unless covered under a Point-of-Service (POS) plan.

2. An Eligible Dependent of an Eligible Employee who resides in the Service Area, unless covered under a POS plan. An **Eligible Dependent** means:
   
a. the employee's lawful Spouse, and/or

   b. the employee's child who has not reached the end of the Calendar Year in which he or she reaches age twenty-six (26).

3. A Newborn child of a Covered Dependent child. Coverage for such Newborn child will automatically terminate eighteen (18) months after the birth of the Newborn child.

Unmarried children without dependents of their own may continue coverage from the end of the Calendar Year in which they turn age twenty-six (26) until the end of the Calendar Year in which they reach age thirty (30), if the child meets the following requirements:

1. The child is a Florida resident or a full or part-time student; and

2. The child is not provided coverage under any other group, blanket, franchise health insurance policy or individual health benefits plan, and is not entitled to benefits under Title XVIII of the Social Security Act.

If the child continues coverage beyond the end of the Calendar Year in which the child reaches age twenty-six (26) and is subsequently terminated, the child is not eligible to be covered under the parent’s plan unless the child was continuously covered by other Creditable Coverage without a gap in coverage of more than sixty-three (63) days.

The term child includes the employee's natural born child, Newborn child, step child, or a Foster or legally Adopted child of the employee upon placement in the employee's residence, or at the birth of a Newborn Adopted child, where a written agreement to Adopt such child has been entered into prior to the birth of the child. If the Foster or Adopted child is ultimately not placed in the residence of the employee, no benefit will apply.
The term also includes any child for whom the employee is the court-appointed legal guardian, a child who is dependent on the employee for health care coverage pursuant to a Qualified Medical Child Support Order (QMCSO), or any child who lives with the employee in a normal parent-child relationship, if the child qualifies at all times for the dependent exemption, as defined in the Internal Revenue Code and the Federal Tax Regulations.

The Health Plan reserves the right to periodically audit dependent eligibility status and to request proof of a child’s dependency status at any time.

**EXTENSION OF ELIGIBILITY FOR DEPENDENT CHILDREN WITH DISABILITIES**

In the case of a handicapped dependent child, such child is eligible to continue coverage as a Covered Dependent beyond the limiting age described above if the child is, and continues to be, both:

1. incapable of self-sustaining employment by reason of mental retardation or physical handicap, and
2. chiefly dependent upon the Covered Employee or Covered Employee’s Covered Spouse for support and maintenance.

The term support, as used in the above definition, includes an Eligible Dependent that is claimed as a dependent on the Covered Employee’s Federal Tax Return.

If a claim is denied for the stated reason that the child has reached the limiting age for dependent coverage, the Covered Employee has the burden of establishing that the child is and continues to be handicapped as defined above.

The coverage of the handicapped child may be continued, but not beyond the termination date of such incapacity or such dependence. In no event shall this provision limit the application of any other provision of the Health Plan terminating such child’s coverage for any other reason other than the attainment of the applicable limiting age.

**OTHER REQUIREMENTS/RULES REGARDING ELIGIBILITY**

1. No individual whose coverage with the Health Plan has been terminated for cause or any other reason listed in the Disenrollment For Cause provision within the Termination Provisions section below shall be eligible for coverage with the Health Plan.

2. No person shall be refused enrollment or re-enrollment with the Health Plan because of race, color, creed, marital status, gender, or age (except as provided above within this section).

3. The Certificate Holder must notify us as soon as possible when a Covered Dependent is no longer eligible for coverage. If a Covered Dependent fails to continue to meet each of the eligibility requirements under this Certificate, and such proper notification is not timely provided by the Certificate Holder to us, we shall have the right to retroactively terminate coverage of such Covered Dependent to the date any such eligibility requirement was not met and to recover an amount equal to the Allowed Amount for Health Care Services provided following such date, less any Premiums and other
applicable charges received by us for such dependent for coverage after such date. We reserve the right to request that the Covered Employee provide proof, which is acceptable to us, of a Covered Dependent’s continued eligibility for coverage.

B. ENROLLMENT TIME FRAMES

Any individual who is not properly enrolled hereunder will not be covered under this Certificate. We will have no obligation whatsoever to any individual who is not properly enrolled.

There are four (4) time periods during which an Eligible Employee or Eligible Dependent can enroll for coverage under this Group Plan:

1. The Initial Enrollment Period is the period of time during which an employee or dependent is first eligible to enroll. It begins on an employee’s or dependent’s initial date of eligibility and ends thirty-one (31) days later.

2. The Open Enrollment Period is an annual period defined by the Employer, during which:
   a. If the Employer offers more than one health plan option through the Health Plan, an employee may change to one of the alternatives offered.
   b. Employees who decided not to enroll for coverage under the Health Plan during the Initial Enrollment Period may now enroll themselves and their Eligible Dependents.

3. A Special Enrollment Period of thirty-one (31) days is provided for special circumstances described in the Special Enrollment Period provision section.

4. Within sixty (60) days of losing eligibility for Medicaid or a Children’s Health Insurance Program (CHIP) or becoming eligible for Premium assistance under Medicaid or CHIP.

SPECIAL ENROLLMENT PERIOD

An Eligible Employee or Eligible Dependent may request to enroll in this Group Plan outside of the Initial Enrollment and Open Enrollment Periods if that individual, within the immediately preceding thirty-one (31) days, was covered under another employer health benefit plan as an employee or dependent at the time he or she was initially eligible to enroll for coverage under the Health Plan, and:

1. Demonstrates that they lost coverage due to a loss of eligibility under the prior plan as a result of: legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or termination of coverage due to the termination of employer contributions toward such coverage;

2. Requests enrollment within thirty-one (31) days after the termination of coverage under the other employer health benefit plan; and

3. Provides proof of continuous coverage under the other employer health benefit plan.
In addition, a Special Enrollment Period will be extended to Covered Employees acquiring a dependent through marriage, birth, Adoption, or placement for Adoption even when other coverage is not lost. Qualifying Events considered eligible for Special Enrollment provisions are defined by Section 125 of the Internal Revenue Code.

When coverage is requested within thirty-one (31) days of the Qualifying Event or termination of other employer sponsored coverage, enrollment will be allowed outside of the Initial Enrollment and Open Enrollment Periods, with coverage becoming effective on the date of the Qualifying Event or retroactively to the date coverage terminated.

C. ENROLLMENT PROCEDURES

Eligible Employees and Eligible Dependents that become covered under the Health Plan will be referred to as "Insured". To become an Insured, the employee must:

1. Complete and submit, through their employer, a request for coverage using enrollment forms approved by the Health Plan within the eligibility period;

2. Provide any additional information needed to determine eligibility, if requested by the Health Plan; and

3. Agree to pay his or her portion of the required Premium, if required by the employer.

Eligible Employees and Eligible Dependents that do not enroll within the Initial Enrollment Period must wait until the next Open Enrollment Period to enroll, unless they qualify earlier due to circumstances provided for under the Special Enrollment Period provision.

D. EFFECTIVE DATES

The Effective Date of an Insured under the Health Plan depends upon when they enroll, as described below.

1. If the Insured is eligible for coverage on the Group Plan Effective Date, coverage will be effective on the Group Plan Effective Date.

2. If the Insured becomes eligible after the Group Plan Effective Date and enrolls during the Initial Enrollment Period, coverage will be effective on the date the employee becomes eligible. This includes those new employees required to fulfill an employer Waiting Period (see Waiting Period in the Definitions section of this Certificate).

3. If the Insured qualifies and enrolls as a special enrollee, coverage will become effective on the date of the Qualifying Event (i.e., marriage, birth, termination of other group coverage, etc.). If the Insured qualifies and enrolls as a full-time student, coverage will become effective on the date classes begin for the specified term.

4. If the Insured enrolls during the Open Enrollment Period, coverage will become effective on the Anniversary Date.

E. DEPENDENT ENROLLMENT

An individual may be added upon becoming an Eligible Dependent of a Covered Employee.
Newborn Child – To enroll a Newborn child who is an Eligible Dependent, you must submit, through your employer, a request for coverage using enrollment forms approved by us within the eligibility period. The following guidelines will be applied when enrolling a Newborn child:

1. If we receive written notice within thirty-one (31) calendar days after the date of birth, the Effective Date of coverage will be the date of birth, and no Premium will be charged for the Newborn child for the first thirty-one (31) calendar days of coverage.

2. If we receive written notice thirty-two (32) to sixty (60) calendar days after the date of birth, the Effective Date of coverage will be the date of birth, and the appropriate Premium will be charged from the date of birth.

3. If notice of the birth is not given within sixty (60) days of birth, the Newborn child will be considered a late enrollee and ineligible to enroll for coverage until the next annual Open Enrollment Period.

Coverage for a Newborn child of a Covered Dependent of the Covered Employee, other than the Covered Employee’s Spouse, will automatically terminate eighteen (18) months after the birth of the Newborn child, as long as the Covered Dependent remains an eligible enrolled dependent of the Covered Employee.

Adopted Newborn Child – To enroll an Adopted Newborn child, you must submit, through your employer, a request for coverage using enrollment forms approved by us within the eligibility period. The Effective Date of coverage for an Adopted Newborn child who is eligible for coverage shall be the moment of birth, provided that timely notice is given and a written agreement to Adopt such child has been entered into by the Covered Employee prior to the birth of such child, whether or not such an agreement is enforceable. We may require you to provide any information and/or documents which we deem necessary in order to administer this provision. The following guidelines will be applied when enrolling an Adopted Newborn child:

1. If we receive written notice within thirty-one (31) calendar days after the date of birth, the Effective Date of coverage will be the date of birth, and no Premium will be charged for the first thirty-one (31) calendar days of coverage for the Adopted Newborn child.

2. If we receive written notice thirty-two (32) to sixty (60) calendar days after the date of birth, the Effective Date of coverage will be the date of birth, and the appropriate Premium will be charged from the date of birth.

3. If notice is not given within sixty (60) calendar days of birth, the Adopted Newborn child will be considered a late enrollee and ineligible to enroll for coverage until the next annual Open Enrollment Period.

For all children covered as Adopted children, if the final decree of Adoption is not issued, coverage shall not be continued for the proposed Adopted child under this Certificate. Proof of final Adoption must be submitted to us. It is your responsibility to notify us if the Adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the Adopted Newborn child on the first billing date following our receipt of the written notice.

Adopted/Foster Children – To enroll an Adopted child (other than a Newborn) or Foster Child, you must submit, through your employer, a request for coverage using enrollment forms
approved by us within the eligibility period immediately following the date of birth or placement. The Effective Date for an Adopted or Foster Child (other than an Adopted Newborn child) shall be the date such Adopted or Foster Child is placed in the Certificate Holder’s residence pursuant to Florida law, provided that timely notice is given. We may require you to provide any information and/or documents deemed necessary by us in order to properly administer this provision. The following guidelines will be applied when enrolling an Adopted or Foster Child:

1. If the Adopted or Foster Child is enrolled within thirty-one (31) calendar days, the Effective Date of coverage will be the date of placement in the Certificate Holder’s residence, and no Premium will be charged for the first thirty-one (31) calendar days of coverage.

2. If the Adopted or Foster Child is enrolled within thirty-two (32) to sixty (60) calendar days, the Effective Date of coverage will be the date of placement in the Certificate Holder’s residence, and the appropriate Premium will be charged from the date of placement. The Adopted or Foster child will not be denied coverage if notice is received from the Covered Person within sixty (60) days of the birth or placement of the child.

For all children covered as Adopted children, if the final decree of Adoption is not issued, coverage shall not be continued for the proposed Adopted child. Proof of final Adoption must be submitted to us. It is your responsibility to notify us if the Adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child on the first billing date following receipt of the written notice.

If your status as a foster parent is terminated, coverage shall not be continued for any Foster Child. It is your responsibility to notify us that the Foster Child is no longer in your care. Upon receipt of this notification, we will terminate the coverage of the child on the first billing date following receipt of the written notice.

Marital Status – You may apply for coverage for an Eligible Dependent Spouse due to marriage. To enroll a Spouse, you must submit, through your employer, a request for coverage using enrollment forms approved by us within the thirty-one (31) day period immediately following the date of marriage. If you apply for coverage for an Eligible Dependent Spouse within thirty-one (31) days following the date of marriage, the Effective Date of coverage shall be no later than the first day of the first month beginning after the date the completed request for enrollment is received by us.

Court Order – You may apply for coverage for an Eligible Dependent if a court has ordered coverage to be provided by you for a minor child. To apply for coverage, you must submit, through your employer, a request for coverage using enrollment forms approved by us. The Effective Date of coverage for the Eligible Dependent shall be determined by us.

Other Dependents – If other Eligible Dependents were not named on the application for this Certificate, you may apply for coverage for the Eligible Dependents during a Special Enrollment Period. Newly Eligible Dependents can become covered when you file the required enrollment forms to your employer. If notice of the newly Eligible Dependent is not given during the Special Enrollment Period, the dependent will be ineligible to enroll for coverage until the next annual Open Enrollment Period.
F. TERMINATION PROVISIONS

Because this plan provides group coverage, the continuation of the coverage depends on the decisions of the employer and on the Covered Employee's continued employment relationship to the employer. The following sections explain when coverage will end and the options available to the Insured to continue coverage.

An Insured's coverage under this Group Plan will end automatically at 11:59 pm, Eastern Standard Time, [insert date]:

1. The contract between the Large Employer and the Health Plan terminates; or

2. The Insured's coverage is terminated for cause (see the Termination of an Individual's Coverage for Cause provision below); or

3. The Insured no longer meets eligibility requirements.

VOLUNTARY TERMINATION OF COVERAGE

An Insured may voluntarily terminate coverage during the Open Enrollment Period by signing and submitting an Enrollment Status Change form to their employer. This termination will be effective the first (1st) day of the first (1st) month following receipt of such Enrollment Status Change form. Non-payment of Premium does not constitute voluntary termination.

TERMINATION OF AN INDIVIDUAL’S COVERAGE FOR CAUSE

Unless otherwise prohibited by law, if, in the Health Plan’s opinion, any of the following events occur, an Insured’s coverage may be terminated:

1. The date specified by the Health Plan due to the Insured’s disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that such Insured’s continued coverage in the Health Plan impairs the Health Plan’s ability to provide coverage and/or arrange for the delivery of Health Care Services to the Insured. Prior to disenrolling an Insured for any of the above reasons, the Health Plan will:

   a. Make a reasonable effort to resolve the problem presented by the Insured, including the use or attempted use of the Health Plan's Grievance procedure;

   b. To the extent possible, ascertain that the Insured’s behavior is not related to the use of medical services or mental illness; and

   c. Document the problems encountered, efforts made to resolve the problems, and any of the Insured’s medical Conditions involved.

2. The date specified by the Health Plan that all coverage will terminate due to: (a) fraud or intentional misrepresentation of a material fact in applying for or presenting any claim for benefits under this Group Plan; (b) permitting the use of their Plan ID card by non-insured; or (c) furnishing of false or incomplete information on the enrollment application for the purpose of fraudulently obtaining benefits. Examples of false, material information include information relating to residence or another person's eligibility for coverage or status as a dependent. If such activity does occur, the Health Plan reserves...
the rights to recoup any funds paid out under false pretenses and/or rescind the plan in its entirety.

3. The date specified by the Health Plan if the Insured leaves the Health Plan's Service Area and no longer meets the eligibility requirements as stated under the Eligibility Under this Group Plan section.

Any termination made under these provisions is subject to review in accordance with the Grievance procedure described herein.

“Time Limit on Certain Defenses” is relative to a misstatement in the application. After two (2) years from the Effective Date, only fraudulent misstatements in the application may be used to void the coverage or deny any claims for losses incurred after the two (2) year period.

TERMINATION DATE OF COVERED PERSON

A Covered Employee’s coverage will terminate at midnight Eastern Standard Time on the date specified by the Health Plan in accordance with the Termination provisions described above.

TERMINATION OF A COVERED DEPENDENT

A Covered Dependent’s coverage will automatically terminate:

1. At midnight on the date the Covered Employee’s coverage terminates for any reason;

2. If the Covered Dependent fails to continue to meet any of the applicable eligibility requirements;

3. On the date we specify that the Covered Dependent’s coverage is terminated by us for cause.

In the event the Covered Employee wishes to delete a Covered Dependent from coverage, he or she must submit, through their employer, an Enrollment Change Form prior to the required termination date. You may contact your employer to obtain the required form.

In the event the Covered Employee wishes to terminate a Spouse’s coverage (e.g., in the case of divorce), you must contact your employer to obtain the appropriate documentation and your employer will then submit the documentation to the Health Plan.

TERMINATION OF A SPOUSE’S AND/OR SPOUSE’S DEPENDENT CHILD’S COVERAGE

In addition to the provision stated in the Termination of a Covered Dependent subsection, the Covered Spouse and the Covered Spouse’s Covered Dependent child’s coverage under the Certificate will terminate at midnight on the date that the marriage terminates or the date of death of the Spouse. The Covered Employee must notify us within ten (10) calendar days of when the Spouse’s eligibility requirements are no longer met or within ten (10) calendar days of the death of the Covered Spouse.
G. RESCISSION OF COVERAGE

We reserve the right to rescind the coverage under this Certificate as permitted by law. The Health Plan can only rescind the Certificate or coverage of an individual covered under the Certificate if you or another person on your behalf commits fraud or intentional misrepresentation of material fact.

We will provide you at least forty-five (45) calendar days advance written notice to you of our intent to rescind coverage.

Rescission of coverage is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review procedure described in the Claims Provisions section of this Certificate.

H. CERTIFICATE OF CREDITABLE COVERAGE

Within thirty-one (31) days of an Insured’s last date of coverage under the Health Plan, a Certificate of Creditable Coverage will be produced and mailed to the Insured’s last known address on file. This Certificate will indicate who was covered under the Group Plan and the period of time the Insured was enrolled under the Group Plan. The Certificate of Creditable Coverage provides evidence of an Insured’s coverage that may be needed when applying for future health coverage. To request a Certificate of Creditable Coverage while your coverage is still in force, please contact our Customer Service Department at (844) 522-5279.

I. GROUP PLAN REPLACEMENT

If this Group Plan immediately replaces another group plan, each Insured who was covered by the prior health plan (e.g. employees, dependents, COBRA continuant, and Insured on sick leave, out ill, or on maternity leave) will be covered by the health plan and the Extension of Benefits rule described below will apply.

J. EXTENSION OF BENEFITS

In the event this Group Plan is terminated in its entirety and an Insured is totally disabled on the date the Group Plan is terminated, the benefits described in the Covered Services section will be payable, subject to the regular benefit limits described in the Covered Services and Exclusions and Limitations sections, for expenses incurred due to the Sickness or Injury which caused such continuous total disability. This extension of benefits will cease on the earliest of:

1. The date on which the continuous total disability ceases; or
2. The end of the twelve (12) month period immediately following the termination date of the Group Plan; or
3. The group secures replacement coverage from another health care benefit plan that covers the Sickness or Injury causing the total disability.

For pregnancy, services directly related to the pregnancy will continue until the pregnancy ends, provided the pregnancy began after the Insured's Effective Date and prior to the termination of the Group Plan. This extension will not be based on total disability.
For the purposes of this section, "continuous total disability" and "totally disabled" mean:

1. For the Covered Employee, the inability to perform any work or occupation for which the Covered Employee is reasonably qualified for or trained.

2. For any other Insured, the inability to engage in most normal activities of a person of like age and sex in good health.

An Insured is not entitled to extension of benefits if coverage is terminated for any of the following reasons:

1. For cause, due to disruptive, unruly, abusive, or uncooperative behavior to the extent that such Insured’s continued coverage in the Group Plan impairs the Health Plan’s ability to administer this Plan or to arrange for the delivery of Health Care Services to such Insured;

2. For fraud or intentional misrepresentation or omission in applying for any benefits under this Group Plan;

3. For failure of the Large Employer to pay the required Premium;

4. For leaving the Health Plan’s Service Area with the intent to relocate or establish a new permanent residence.

K. FEDERAL CONTINUATION OF COVERAGE PROVISIONS

The continuation of coverage provisions described herein apply to employers with twenty (20) or more employees.

Rights to continuation of coverage under the federal law, Consolidated Omnibus Budget Reconciliation Act (COBRA), is applicable to Insured upon termination as described herein.

In order to be eligible for continuation coverage under this federal law, the definition of a Qualified Beneficiary must be met. To be a Qualified Beneficiary, an individual must generally satisfy the following two conditions:

1. The individual must be a Covered Employee, the Spouse of a Covered Employee, or the Eligible Dependent child of a Covered Employee; and

2. The individual must be covered by a group health plan immediately before the Qualifying Event.

Types of Qualifying Events include:

1. Termination of employment for any reason other than gross misconduct;

2. Reduction in a Covered Employee’s hours of employment;

3. Death of the Covered Employee;

4. Divorce or legal separation from the Covered Employee;
5. Ceasing to be an Eligible Dependent under the terms of the Group Plan;  
6. The Covered Employee’s entitlement to Medicare; and  
7. Employer bankruptcy.

Every Qualified Beneficiary must be offered the opportunity to elect COBRA during the election period. A Qualified Beneficiary who has other group health plan coverage or who is entitled to Medicare at the time of a COBRA election is entitled to elect COBRA and may choose to have dual coverage for the entire COBRA coverage period.

**TYPE OF COBRA COVERAGE OFFERED**

COBRA coverage must be identical to the coverage provided to similarly situated beneficiaries under the Health Plan under which a Qualified Beneficiary was covered immediately prior to the Qualifying Event. However, if the Employer Group offers a Point-of-Service (POS) plan, a Qualified Beneficiary may elect COBRA coverage with the POS plan if the Qualified Beneficiary permanently relocates outside the Service Area of the Health Plan. Qualified Beneficiaries who are offered Health Maintenance Organization (HMO) coverage only by their employer are not eligible to continue coverage when permanently relocating outside the Service Area.

COBRA Qualified Beneficiaries may change coverage during the Open Enrollment Period under the same considerations as active employees. A Qualified Beneficiary may do the following things during Open Enrollment under the Health Plan, if a non-COBRA beneficiary is allowed to do so:

1. Change benefit options or packages within the plan under which he or she was covered prior to the Qualifying Event;  
2. Add coverage for Eligible Dependents; and  
3. Switch to other group health plans offered by the Employer Group.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), employees who are eligible to participate in a group health plan have a special right to enroll certain family members upon the loss of other group health plan coverage or upon acquiring a new Spouse or dependent. Once a Qualified Beneficiary is receiving COBRA coverage, the Qualified Beneficiary has the same right to enroll family members under the HIPAA rules as if the Qualified Beneficiary were an active employee or participant in the Health Plan. These rights are only available to Qualified Beneficiaries who timely elected COBRA and who are receiving COBRA continuation coverage.

If the group’s health coverage for active employees changes, the COBRA coverage for similarly situated Qualified Beneficiaries also changes accordingly.

**LENGTH OF COBRA COVERAGE**

COBRA continuation coverage generally starts on the date of the Qualifying Event and may last through the maximum coverage period, depending upon the type of Qualifying Event.
The following types of Qualifying Events have an 18-month maximum coverage period:

1. Terminations of employment.
2. Reductions in hours.

The following types of Qualifying Events have a 36-month maximum coverage period:

1. The death of an employee.
2. Divorce or legal separation of the employee.
3. A child losing dependent status.
4. The employee becoming entitled to Medicare.

EXTENSION OF THE MAXIMUM COVERAGE PERIOD

A Qualified Beneficiary’s maximum coverage period can be extended under the multiple Qualifying Events or the disability extension rules described below. COBRA does not require that a Qualified Beneficiary be given notice of such an extension.

Multiple Qualifying Events

The 18-month maximum coverage period for termination of employment or reduction in employment hours can be extended for multiple Qualifying Events, such as divorce commencing after the initial Qualifying Event of termination of employment. If, during the 18-month coverage period, the Covered Employee dies, the Covered Employee divorces or legally separates, the Covered Employee becomes entitled to Medicare, or the Covered Employee’s child ceases to be a dependent, the maximum coverage period is extended to thirty-six (36) months, measured from the date that the 18-month period initially started.

Disability Extension

If all of the conditions listed below are met, then the maximum coverage period for all Qualified Beneficiaries (including the employee) who became eligible for COBRA as a result of the same Qualifying Event is extended to twenty-nine (29) months. This is measured from the date that the 18-month period initially started.

1. A Qualified Beneficiary is disabled (as determined by the Social Security Administration) on any day during the first sixty (60) days of COBRA continuation coverage;
2. The Qualifying Event was the reason for the Covered Employee’s termination of employment or reduction in hours; and
3. The Qualified Beneficiary notifies the Plan Administrator within sixty (60) days after the Social Security Administration’s determination of disability and before the end of the original 18-month maximum coverage period.
EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

The Health Plan can terminate a Qualified Beneficiary’s COBRA coverage before the maximum coverage period (including any extension) expires if any one of the following events occurs:

1. The required Premium for the Qualified Beneficiary’s coverage is not paid on time (subject to COBRA grace periods);
2. The Qualified Beneficiary becomes entitled to Medicare benefits after electing COBRA coverage;
3. The Qualified Beneficiary becomes covered by another group health plan after electing COBRA coverage;
4. The employer ceases to maintain any group health plan for any employee;
5. If the maximum coverage period has been extended under the disability extension, the Qualified Beneficiary who had been determined to be disabled is determined not to be disabled (COBRA coverage may be terminated for all Qualified Beneficiaries receiving extended COBRA coverage under the disability extension); or
6. For cause.

COVERAGE DURING COBRA ELECTION AND PREMIUM PAYMENT PERIODS

The Health Plan will not provide COBRA coverage to a Qualified Beneficiary until a timely election is made and required Premiums are paid. Once COBRA coverage is elected and Premiums are paid, COBRA coverage will be reinstated back to the date of termination.

COBRA ELECTION PROCESS

The COBRA election process begins with a notice to the Plan Administrator that a Qualifying Event has occurred. The Employer Group has the obligation to notify the Plan Administrator when a Qualified Beneficiary loses or will lose coverage due to: termination or reduction in hours of a Covered Employee’s employment, death of the Covered Employee, the Covered Employee becoming entitled to Medicare, or the employer’s bankruptcy. The Plan Administrator must be notified within thirty (30) days of the Qualifying Event. In the case of divorce or legal separation or a child’s ceasing to be covered as a dependent under plan rules, the participant or Qualified Beneficiary must notify the Plan Administrator within sixty (60) days of the Qualifying Event. The Plan Administrator then has fourteen (14) days after receiving a Qualifying Event notice to notify each Qualified Beneficiary of his or her rights under COBRA.

COBRA continuation is not automatic. A Qualified Beneficiary must affirmatively elect COBRA coverage within sixty (60) days of the date the Plan Administrator provides the COBRA election notice by returning a written election to the Plan Administrator. Each Qualified Beneficiary has an independent right to elect COBRA coverage.

The Trade Act of 2002 amended COBRA to create a special second sixty (60) day election period for certain workers who did not elect COBRA coverage during the regular sixty (60) day election period. This special second election period is available only in limited circumstances for certain individuals who have been affected by import competition or shifts abroad of
production capacity and who are receiving trade adjustment assistance under the Trade Act of 1974.

**COBRA PREMIUM**

The COBRA Premium for a month’s coverage will be 102% of the applicable plan Premium. There is an exception for coverage for a disabled Qualified Beneficiary during the disability extension in which the COBRA Premium will be 150% of the applicable plan Premium during the disability extension period.

Payment for the initial Premium is due no later than forty-five (45) days after the Qualified Beneficiary elects COBRA. Subsequent Premiums are due on the first day of each month, subject to a thirty (30) day Grace Period. A Premium payment is considered a shortfall and will be considered as non-payment of Premium if the amount owed is greater than $50 or 10% of the outstanding COBRA Premium.

Additional information pertaining to COBRA is available from the United States Department of Labor.

**L. THE CONVERSION PRIVILEGE**

A Covered Employee, who has been continuously covered for at least three (3) months under this Group Plan and/or under another group plan providing similar benefits in effect immediately prior to this Group Plan, has the right to apply for a conversion plan if coverage terminates due to the Covered Employee’s:

1. Termination of employment;
2. Termination of the Covered Employee’s Covered Membership in an eligible class;
3. Loss of coverage due to the termination of this Group Plan, if it is not replaced by another health care plan within thirty-one (31) days of termination.

A Covered Employee’s dependents that are covered as dependents under this Group Plan may also convert, but only as dependents of the Covered Employee, not on their own. However, when a Covered Employee’s dependents have been covered for three (3) consecutive months before coverage ends, they may, on their own, convert to a conversion plan under one of the following conditions:

1. If the Covered Employee’s conversion coverage terminates, Covered Dependents may convert under a new conversion plan.
2. If the covered Spouse is no longer an Eligible Dependent as defined in this Group Plan, the Spouse may convert.
3. If a Covered Dependent child is no longer an Eligible Dependent as defined in this Group Plan, such dependent may convert.

At the time of application, the eligible Insured will be offered a choice of at least two plans. The new coverage will be issued at rates, not to exceed 200% of the Standard Risk Rate as
determined and published by the Florida Department of Financial Services, Office of Insurance Regulation.

REQUESTING CONVERSION

An Insured who is eligible for conversion may obtain conversion coverage without having to submit evidence of health qualification. The Insured must apply in writing and pay the first month’s Premium for the conversion plan within sixty-three (63) days after his or her coverage under this Group Plan terminates. The application form to be used and information about conversion benefits may be obtained from the Health Plan.

If the employer qualifies for federal continuation benefits described in the Federal Continuation of Coverage Provisions section above, conversion must not take place until the exhaustion of the federal continuation period.

Unless otherwise prohibited by law, conversion is not available if:

1. The Insured has not been continuously covered for at least three (3) months under this Group Plan and/or under another group plan providing similar benefits maintained by the employer, in effect immediately prior to the termination of this Group Plan;

2. The Insured is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or by another plan or program;

3. The Insured is eligible for similar benefits, whether or not actually provided coverage, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis;

4. Similar benefits are provided for or are available to the Insured under any state or federal law;

5. This Group Plan is replaced by similar group coverage within thirty-one (31) days of the termination date of this Group Plan;

6. Federal Continuation coverage, if available or had been available, has not been elected or exhausted;

7. The Insured has left the Health Plan’s Service Area with the intent to relocate or establish a new permanent residence; or

8. Coverage under this Group Plan ends due to failure to pay any required Premium or contribution, unless such nonpayment of Premium was due to acts of an employer or person other than the individual.

M. DISCRETIONARY AUTHORITY

The Health Plan has the sole discretionary authority to determine eligibility, to construe terms of this Group Plan, and to make decisions concerning claims for benefits under the terms of this Group Plan. The Health Plan may delegate this discretionary authority to other persons or
entities with request to the administration of this Group Plan and is not required to provide notice or obtain approval from the Insured or Large Employer.

Under certain circumstances, the Health Plan, at its sole discretion, may occasionally offer benefits for services that are otherwise not Covered Services under this Group Plan, and doing so in a particular case does not require the Health Plan to do so in any other case.

N. CONFORMITY WITH STATE STATUTES

The validity, construction, and interpretation of this Certificate of Coverage shall be governed by the laws of the State of Florida to the extent there is no conflict with applicable federal law and regulations with respect to an ERISA-Regulated Plan.

Any provision of this Group Plan which, on its Effective Date, is in conflict with the statutes of the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

O. CHANGE OF BENEFICIARY

The Insured can change the beneficiary at any time by giving the insurer written notice. The beneficiary’s consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

III. COVERAGE PROVISIONS

This section provides information about the guidelines Covered Persons must follow in accessing care. It is important that Covered Employees and their Covered Dependents become familiar with the guidelines for accessing Health Care Services through the Health Plan. The following sections explain the role of the Health Plan and the Primary Care Physician, how to access primary and specialty care through the Health Plan, what to do if Emergency Services or Care are needed, and the Prior Authorization provision. Coverage access guidelines may differ with a Point-of-Service (POS) plan.

A. CHOOSING A PRIMARY CARE PHYSICIAN

Under your the Health Plan Group Plan, you are not required to select a Primary Care Physician (PCP) before services are covered. You are free to seek an appointment with any Network Provider.

We strongly encourage you, however, to consider using our Network of Participating Primary Care Physicians to help you coordinate your care and to help you navigate the care provided by the Participating Specialists and Participating Facilities within your Health Plan Provider Network. Covered Persons are free to choose any PCP from the published list of Primary Care Physicians whose practices are open to new patients. Selecting a PCP does not prevent the Insured from obtaining care elsewhere in the Network, and referrals are not required to access specialty care.

A relationship with a PCP can enhance the quality of medical care received through coordination and direction of all necessary medical services. The Insured should look to the PCP to direct his/her care and should consider procedures and/or treatment recommended by the PCP.
B. ACCESSING SPECIALTY CARE

Whether enrolled in an HMO or POS plan, the Health Plan does not require an Insured to obtain a referral from the PCP prior to seeking services from a participating Specialist. However, certain participating Specialists will not accept appointments directly from an Insured that has not been referred for care. In these instances, an Insured will first need to see a PCP. Although the Health Plan operates as an “Open Access” HMO, it is still strongly recommended that an Insured coordinate all care they are receiving from a Specialist with their PCP.

If a non-participating Specialist is required because services are not available within the Participating Provider Network, the PCP or participating Specialist will submit a request for authorization of coverage for such treatment to the Health Plan.

For HMO Covered Persons, Prior Authorization is required for all services and supplies received from a Non-Participating Provider, except for Emergency Services and out-of-area Urgent Care. If such Out-of-Network services and supplies are not authorized in advance by the Health Plan, whether referred by the Participating Provider or not, the Covered Person will not have coverage for the services or supplies.

C. ADDITIONAL HEALTH CARE PROVIDER INFORMATION

If a Participating Provider terminates his or her contract with the Health Plan or is terminated by the Health Plan for any reason other than for cause, an Insured receiving active treatment may continue coverage and care with that Provider (as long as the terminated Provider agrees to continue treating the patient at the contracted reimbursement rate) when Medically Necessary and through completion of treatment of a Condition for which the Insured was receiving care at the time of the termination. Access to such terminated Provider may continue through the current period of active treatment or up to ninety (90) calendar days, whichever is less. In the case of a pregnant Insured who has initiated a course of prenatal care with the terminated Provider, continuation of care through the postpartum period can remain in their second or third trimester of pregnancy.

A Provider (PCP or Specialist) may refuse to continue to provide care to an Insured who is abusive, non-compliant, or in arrears in payment for services provided.

An Insured in active course of treatment should contact the Health Plan to assist in coordinating continued coverage with the terminated Provider or affecting the transfer to another Participating Provider. Prior Authorization for continuation of care with a terminated Provider is required for all HMO Covered Persons in order for the services to be covered by the Health Plan.

D. EMERGENCY AND URGENT CARE SERVICES

EMERGENCY SERVICES AND CARE

In the event of an Emergency Medical Condition, the Insured should seek care at the closest medical facility available without regard to the Network participation status of the facility. Emergency Services for treatment of an Emergency Medical Condition are covered In-Network and Out-of-Network without the need for Prior Authorization from the Health Plan. An Emergency Medical Condition is defined as:
1. A medical Condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

   a. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.
   b. Serious impairment to bodily functions.
   c. Serious dysfunction of any bodily organ or part.

2. With respect to a pregnant woman:

   a. That there is inadequate time to effect safe transfer to another Hospital prior to delivery, and
   b. That a transfer may pose a threat to the health and safety of the patient or fetus, or
   c. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Coverage will be provided for medical screening, examination, and evaluation by a Physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Physician, to determine if an Emergency Medical Condition exists. If it is determined that an Emergency Medical Condition exists, the care, treatment, or surgery necessary to relieve or eliminate the Emergency Medical Condition, within the service capability of a Hospital, is covered. If care is sought for a non-Emergency Medical Condition, payment shall be limited to costs for the determination of whether an Emergency Medical Condition existed and no further benefits will be paid.

More than one Cost-Share may apply to services provided in an emergency room setting. For example, some plans include a Cost-Share for the emergent visit and separate Cost-Shares for additional services, such as advanced imaging, if applicable. See your Schedule of Benefits for details.

In the event of an Emergency Medical Condition, the Insured or the Insured's family should notify the Health Plan as soon as reasonably possible. Only the initial treatment, as described above, is covered without authorization at non-participating facilities for HMO Covered Persons. All follow-up care must be coordinated and authorized according to the provisions of this Group Plan to ensure proper coverage under this Plan.

Payment Rules for Emergency Services and Care

Payment for Emergency Services and Care rendered by a Non-Participating Provider that has not entered into an agreement with the Health Plan to provide access at a discount from the billed amount of that Provider shall be the lesser of:

1. The Provider's charges;

2. The usual and customary Provider charges for similar services in the community where the services were provided; or
3. The charge mutually agreed to by the Health Plan and the Provider within sixty (60) days of the submittal of the claim.

Such payment shall be the net of any applicable Cost-Share.

**URGENT CARE**

Urgent Care services are covered both inside and outside the Service Area. Inside the Service Area, Covered Persons enrolled in an HMO plan must utilize participating Urgent Care centers. Outside the Service Area, coverage is provided at a non-participating Urgent Care center or licensed Physician office. For HMO Covered Persons, coverage outside the Service Area is also limited to care for Conditions which, although not life-threatening, could result in serious health consequences if not treated within twelve (12) hours and were unforeseeable prior to leaving the area. Applicable Cost-Share amounts for both in and out of area covered care are listed in the Schedule of Benefits attached to this Certificate.

**E. PRIOR AUTHORIZATION**

In order for certain services to be covered, prior approval by the Health Plan is required. This provision includes services such as Inpatient care, certain diagnostic and medical procedures, certain pharmaceutical services (for Group Plans that include a Prescription Drug Rider), and all Out-of-Network services (except for Emergency Medical Conditions or Urgent Care) received by HMO Covered Persons. If services requiring Prior Authorization are obtained without proper authorization, the Insured may be responsible for their entire cost. Services requiring Prior Authorization are subject to change without prior notice and at the sole discretion of the Health Plan. A current list of services requiring Prior Authorization is available through the Health Plan’s Customer Service Department and is posted on the Health Plan’s website at [www.myFHCA.org](http://www.myFHCA.org).

When Prior Authorization is required, the Provider must submit a written authorization request with supporting clinical information to the Health Plan for review. The Provider requesting the authorization will be considered an authorized representative of the Insured during the Prior Authorization process. All related communications will be directed from the Health Plan to the requesting Provider, who will communicate with the Insured. If authorization is denied for any reason, both the Insured and the requesting Provider will receive a notice explaining the reason for the denial and the process for filing an Appeal.

Insureds covered under a Point-of-Service (POS) plan who utilize their Out-of-Network benefits for non-Emergency Services or non-Urgent Care bear an additional responsibility of ensuring that any Out-of-Network Providers who may not be familiar with the Health Plan’s authorization requirements secure the appropriate authorizations prior to receiving care.

**EXPEDITED AUTHORIZATIONS**

A decision will be made and the requesting Provider and Insured will be notified within twenty-four (24) hours (one calendar day) of an Expedited Authorization request. Written notice of the decision will be provided to the requesting Provider and Insured within three (3) calendar days of the Expedited Authorization request.

If additional information is required in order to make a decision, the information will be requested from the Provider within twenty-four (24) hours of the Prior Authorization request. The Provider
will have forty-eight (48) hours (two calendar days) from the time requested to provide the additional information. A decision will be made and the requesting Provider will be notified within forty-eight (48) hours (two calendar days) after the earlier of (a) the receipt of requested information or (b) the end of the period afforded to submit the information. Written notice of the decision will be provided within three (3) calendar days.

STANDARD PRE-SERVICE AUTHORIZATIONS

A decision will be made and the requesting Participating Provider and Insured will be notified within fourteen (14) calendar days of a standard pre-service authorization request. If an extension is necessary due to circumstances beyond the Health Plan’s control, a fourteen (14) calendar day extension may be applied, for a total of twenty-eight (28) calendar days to render a decision. If the delay is due to additional information being required in order to make a decision, the information will be requested from the requesting Provider within fourteen (14) calendar days of the Prior Authorization request. The Provider will have forty-five (45) calendar days within which to provide the requested information. A decision will be made, and the requesting Provider and Insured will be notified within fourteen (14) calendar days after the earlier of (a) the receipt of requested information or (b) the end of the period afforded to submit the information.

CONCURRENT CARE

If ongoing care has been approved over a period of time or in a specified number of treatments, and the Insured or treating Provider wishes to extend the course of treatment, the Insured, through their treating Provider, must request the Health Plan to continue the ongoing care at least twenty-four (24) hours prior to the end of the approved course of treatment.

Standard concurrent care decisions will be made and the treating Provider and Insured will be notified within seventy-two (72) hours (three calendar days). Expedited concurrent care decisions will be made and the treating Provider and Insured will be notified within twenty-four (24) hours (one calendar day) of the Health Plan receiving the request. The Health Plan may extend the expedited concurrent care decision time frame by an additional forty-eight (48) hours (two calendar days), allowing up to seventy-two (72) hours (three calendar days) to render a decision. Such extension may be provided when:

1. A request to extend the expedited concurrent care was made within the original twenty-four (24) hour decision time frame.

2. The request is related to care not previously approved for the Insured by the Health Plan, and the Health Plan documents that it made at least one attempt to obtain the necessary clinical information, but was unsuccessful, within the initial twenty-four (24) hours of the request.

3. The Insured voluntarily agrees to extend the decision-making time frame.

F. MEDICAL PAYMENT GUIDELINES FOR NON-PARTICIPATING PROVIDER CARE

If the Insured requires care from a Provider type that the Health Plan does not have under contract, arrangements will be made by the Health Plan to provide the appropriate care elsewhere. These services will be covered under the In-Network level of benefits for both HMO and POS Covered Persons provided that such services are authorized and approved as such in advance by the Health Plan.
The Health Plan’s payment for Covered Services will be limited by the Medical Payment Guidelines then in effect. These guidelines include the following:

1. The payment of expenses for Covered Services received from Non-Participating Providers is limited to payment for the most cost-effective procedures, treatment, services and supplies that are provided in the most cost-effective setting. For example, services are limited to the most cost-effective Prosthetic Device, Orthotic Device, or Durable Medical Equipment that will restore to the Covered Person the function lost due to the Condition.

2. Payments for many services and/or supplies are included within the Allowance for the primary procedure; therefore, no additional amount is payable by the Health Plan or the Insured for certain services and/or supplies. The Health Plan follows Medicare guidelines regarding separate payment for services and payment reductions for multiple procedures.

3. The Health Plan’s payment is based on the Allowed Amount for the actual service rendered (for example, not based on the Allowed Amount for a service which is more complex than the service actually rendered), and is not based on the method utilized to perform the service nor the day of the work or time of day the procedure is performed. For example, charges for after-hours care are not covered.

G. POS GUIDELINES FOR OUT-OF-NETWORK COVERED SERVICES & BENEFITS

These provisions apply to Point-of-Service (POS) plans that may be purchased by the Large Employer at an additional expense. The attached Schedule of Benefits will identify whether or not you have a traditional Health Maintenance Organization (HMO) benefit plan or a more flexible POS benefit plan. POS plans allow Covered Persons to seek the specified Covered Services from Participating and Non-Participating Providers. A higher Cost-Share is typically associated with seeking care from Non-Participating Providers, as well as exposure to expenses above the Health Plan’s Allowable Fee Schedule.

ACCESS

Covered Employees and their Covered Dependents are encouraged to select a Primary Care Physician but are not required to do so. An Insured covered under a Point-of-Service (POS) plan may choose to self-refer to a Provider who is not participating with the Health Plan or to a Participating Provider for Covered Services and supplies. Service limits and benefit maximums are calculated by using the sum total of benefits and services provided both In-Network and Out-of-Network.

INSURED FINANCIAL RESPONSIBILITY

In general, when an Insured receives Covered Services, the financial responsibility is any applicable Deductible, Copayment or Coinsurance. Payment may be required at the time services are rendered. An Insured is responsible for satisfying the Calendar Year Deductible, if applicable, before the Coinsurance applies. For a Point-of-Service (POS) Insured, any amount in excess of the Allowable Fee Schedule that is charged by a Non-Participating Provider who has not entered into an agreement with the Health Plan to provide access at a discount is the sole responsibility of the Insured. This amount will not apply towards satisfaction of the Calendar Year Deductible or Out-of-Pocket Maximum Calendar Year Expense Limit. When the
Out-of-Pocket Maximum Expense Limit is satisfied, the Point-of-Service (POS) Insured will continue to be responsible for any charges in excess of the Allowable Fee Schedule for Non-Participating Providers. When seeking Out-of-Network services, these Covered Persons are encouraged to negotiate acceptance of the Health Plan’s Allowable Fee Schedule in advance of seeking treatment in order to lower their out-of-pocket costs.

MEDICAL NECESSITY

All services and supplies covered under the Out-of-Network benefits must be Medically Necessary as defined in the Group Plan. Some services and supplies require approval by the Health Plan prior to the services being rendered.

PRIOR AUTHORIZATION FOR COVERED SERVICES

In order to determine whether services and supplies are Medically Necessary, certain services and supplies require approval from the Health Plan in advance of the services or supplies being received. Under the Out-of-Network benefits section, the Insured is ultimately held responsible for making sure services and supplies have been approved by the Health Plan in advance of receiving them. The Insured will be responsible for the cost of services and supplies if Prior Authorization is required but not obtained, regardless of whether such services or supplies are deemed Medically Necessary.

Services and supplies that require Prior Authorization are detailed in the Health Plan’s Authorization List, available on the Health Plan’s website at www.myFHCA.org or by contacting Customer Service at (844) 522-5279. The Authorization List is updated semi-annually but is subject to change, at the Health Plan’s discretion, without notice.

IV. COVERED SERVICES

This section describes the services and supplies that are covered under this Group Plan. It is important that this whole section, along with the Exclusions and Limitations section that follows, be reviewed to be sure both Covered Service details and the limitations and exclusions are understood. In addition, important information is contained in the Schedule of Benefits and any Riders attached to this Certificate.

All of these provisions should be read carefully to understand the benefits provided under this Group Plan.

The services and supplies listed below will be considered Covered Services under this Group Plan if the service or supply is:

1. Set forth within the Covered Services categories in this section;

2. Authorized and approved by the Health Plan in advance of receiving the services or supplies, except for Urgent or Emergency Services and Care, when such services and supplies are subject to a Prior Authorization requirement (see the Prior Authorization section of this Certificate for more information);

3. Received from or provided by Participating Providers, except for Urgent or Emergency Services and Care, unless covered under a POS plan.
4. Actually rendered while coverage under this Group Plan is in force;

5. Medically Necessary, as defined in this Group Plan; and

6. Not specifically limited or excluded under this Group Plan.

Insured are responsible for the Cost-Share listed in the attached Schedule of Benefits for each category of Covered Services. The payment of expenses for Covered Services received from Non-Participating Providers is subject to the Health Plan's Allowable Fee Schedule.

**Acute Inpatient Rehabilitation Facility Services**
Acute Inpatient Rehabilitation Facility services are covered when considered Medically Necessary by the Health Plan. Coverage is limited to diagnoses of severe stroke, multiple trauma, brain/spinal injury, severe neurological motor disorders, and/or severe burns.

**Alcohol and Substance Abuse Treatment**
Alcohol and substance abuse treatment services and supplies provided by, or under the supervision of, or prescribed by a licensed Physician or licensed psychologist are covered. The program must be accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the State of Florida for the treatment of alcohol or drug dependency. The services covered are as follows:

1. Inpatient treatment for the acute stages of substance abuse or detoxification provided in a general specialty or rehabilitative Hospital and not a residential treatment facility; and
2. Outpatient care services provided or prescribed by, or under the supervision of, a licensed Physician or licensed psychologist. Detoxification services and supplies are not Covered Services when provided on an outpatient basis.

**Allergy Treatments**
Testing and desensitization therapy (e.g., injections) and the cost of hypo sensitization serum are covered. The Allowed Amount for allergy testing is based upon the type and number of tests performed by the Physician. The Allowed Amount for allergy immunotherapy treatment is based upon the type and number of doses.

**Ambulance Services**
Ambulance services are provided for emergent (does not require Prior Authorization) and non-emergent (in accordance with Medicare guidelines) situations if authorized in advance.

Ambulance services by boat, airplane or helicopter will be reimbursed at the Allowed Amount level for a ground vehicle when:

1. The pick-up point is inaccessible by ground transportation;
2. Speed in excess of ground vehicle speed is critical; or
3. The travel distance involved in getting the Insured to the nearest Hospital that can provide proper care is too far for medical safety.

Ambulance services provided without transfer to a facility are not covered.

**Ambulatory Surgical Centers Services and Other Outpatient Medical Treatment Facilities**
The services and supplies listed below that are furnished to an Insured at an Ambulatory Surgical Center or other outpatient medical treatment facility will be considered Covered
Services when authorized and obtained in accordance with all other plan provisions included herein:

1. Use of operating and recovery rooms;
2. Respiratory or inhalation therapy (e.g., oxygen);
3. Drugs and medicines administered at the Ambulatory Surgical Center or other outpatient medical treatment facility (except for take home drugs);
4. Intravenous solutions;
5. Dressing, including ordinary casts, splints or trusses;
6. Anesthetics and their administration;
7. Administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the Exclusions and Limitations section);
8. Transfusion supplies and equipment;
9. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., electrocardiogram (EKG));
10. Imaging services, including CT scans, Magnetic Resonance Imaging (MRI), and Positron Emission Tomography (PET) scans (separate Cost-Share applies);
11. Chemotherapy treatment for proven malignant disease; and
12. Other Medically Necessary services and supplies.

**Anesthesia Administration Services**

Anesthesia services are covered when administered by a Health Care Provider and necessary for a surgical procedure.

**Autism Services and Treatment**

Coverage for autism services and treatment is limited to an Insured under eighteen (18) years of age, or an Insured eighteen (18) years of age or older who is in high school, who has been diagnosed by a qualified Provider approved by the Health Plan as having Autism Spectrum Disorder by age eight (8) years or younger. In addition to well-baby and well-child screening for diagnosis purposes, coverage is provided for the treatment of Autism Spectrum Disorder through Speech Therapy, Occupational Therapy, Physical Therapy, and applied behavior analysis. Applied behavior analysis services shall be provided by an individual certified pursuant to Florida State Statute 393.17 or an individual licensed under Chapter 490 or Chapter 491 of the Florida State Statutes. Coverage shall be limited to treatment that is Medically Necessary and prescribed in accordance with a treatment plan approved by the Health Plan and may not be denied on the basis that services are habilitative in nature. An Insured will need to follow Health Plan guidelines for accessing services.

**Biofeedback Services**

Biofeedback services are covered when considered Medically Necessary by the Health Plan and authorized in advance.

**Blood**

Coverage includes whole blood, blood plasma, blood components and blood derivatives, unless replaced.

**Breast Cancer Treatment**

Coverage for breast cancer treatment includes Inpatient Hospital care and outpatient post-surgical follow-up care for Mastectomies when Medically Necessary in accordance with prevailing medical standards. Coverage for outpatient post-surgical care is provided in the most medically appropriate setting which may include the Hospital, treating Physician’s office,
outpatient center, or the Insured’s home. Inpatient Hospital treatment for Mastectomies will not be limited to any period that is less than that determined by the Participating Physician.

Coverage for Mastectomies includes:

1. All stages of reconstruction of the breast incident to the Mastectomy;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of Mastectomy, including lymphedemas.

**Cancer Diagnosis and Treatment**

Cancer diagnosis and treatment services are covered, unless otherwise excluded, on an Inpatient or outpatient basis, including chemotherapy treatment, x-ray, cobalt, and other acceptable forms of radiation therapy, microscopic tests or any lab tests or analysis made for diagnosis or treatment.

**Cancer Screenings**

Cancer screenings recommended by the United States Preventive Services Task Force (USPSTF) with an “A” or “B” rating are covered as preventive benefits with no Cost-Share. Frequency limits established by the USPSTF or the Health Plan apply. Current recommendations address breast, cervical and colorectal cancers. Skin and prostate cancer screenings are covered with applicable Cost-Sharing amounts.

**Casts and Splints**

Casts and splints are covered when part of the treatment provided in a Health Care Provider Facility, Provider office or in a Hospital emergency room. This does not include the replacement of any of these items.

**Child Cleft Lip and Cleft Palate Treatment**

Health Care Services for child cleft lip and cleft palate, including medical, dental, Speech Therapy, audiology, and nutrition services, for treatment of a child under the age of nineteen (19) who has cleft lip or cleft palate are covered. The Speech Therapy coverage provided herein is subject to the limitation set forth in your Schedule of Benefits for Outpatient Rehabilitation Services. In order for such services to be covered, the Covered Person’s Physician must specifically prescribe such services, and such services must be consequent to treatment of the cleft lip or cleft palate.

**Concurrent Physician Care**

Concurrent Physician care services are covered for approved procedures, including surgical assistance, provided a) the additional Physician actively participates in the Insured’s treatment, b) the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted, and c) the Physicians have different specialties or have the same specialty with different sub-specialties.

**Congenital and Developmental Abnormality**

Congenital and development abnormality services are covered provided the treatment or plastic and Reconstructive Surgery is for the restoration of bodily function or the correction of a deformity resulting from disease or congenital or developmental abnormalities.
Consultations
Consultations provided by a Physician are covered, provided the Insured’s treating Physician requests the consultation and the consulting Physician prepares a written report.

Contraceptive Services (See Family Planning)

Dental Services
Dental Treatment in a Hospital or Ambulatory Surgical Center:

Covered treatment includes general anesthesia and hospitalization services in connection with necessary dental treatment of surgery for:

1. A Covered Dependent child under age eight (8) whose treating Physician, in consultation with the dentist, determines necessary dental treatment is required in a Hospital or Ambulatory Surgical Center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
2. An Insured who has one or more medical Conditions that would create significant or undue medical risk for the individual in the course of delivery of any Medically Necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Necessary dental treatment is that which, if left untreated, is likely to result in a medical Condition. The Health Plan must authorize the use of general anesthesia and Hospital services prior to the treatment. Coverage does not include diagnosis or treatment of dental disease or the services of the dentist or oral surgeon, except as described below.

Other Covered Dental Services:

Coverage is provided for the extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease, and for an oral or dental examination performed on an inpatient basis as part of comprehensive workup prior to renal transplant surgery, or prior to a heart valve replacement.

Dermatological Services
Dermatological services are covered and include dermatological office visits or minor procedures and testing. Services or testing not considered minor or routine in nature may require Prior Authorization.

Diabetes Outpatient Self-Management Services
Diabetes outpatient self-management training and educational services and nutrition counseling (including all Medically Necessary equipment and supplies) to treat diabetes are covered if the Insured’s Primary Care Physician, or treating Physician who specializes in treating diabetes, certifies that the equipment, supplies, or services are Medically Necessary. In order to be covered, diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified Diabetes Educator or a board certified Physician specializing in endocrinology at an approved Facility. Additionally, in order to be covered, a licensed Dietitian must provide nutrition counseling. Covered Services may also include the trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.
Diagnostic and Surgical Procedures Involving Bones or Joints of the Jaw
Diagnostic and surgical procedures involving bones or joints of the jaw and facial region are covered if, under acceptable medical standards, such procedure or surgery is Medically Necessary to treat conditions caused by congenital or developmental deformity, disease, or Injury. Intra-oral Prosthetic Devices are also covered when authorized in advance.

Diagnostic Services
Coverage of diagnostic services, when ordered by a Physician, is limited to the following:

1. Radiology services;
2. Laboratory and pathology services;
3. Services involving bones or joints of the jaw (e.g., services to treat temporomandibular joint (TMJ) dysfunction) or facial region if, under accepted medical standards, such diagnostic services are necessary to treat conditions caused by congenital or developmental deformity, disease, or Injury;
4. Approved machine testing (e.g., electrocardiogram (EKG), electroencephalograph (EEG) and other electronic diagnostic medical procedures); and
5. Genetic testing as defined in this Covered Services section.

Dialysis Services
Dialysis services, including hemodialysis, are covered, including equipment, training, and medical supplies required for home dialysis or when provided in any location (including Dialysis Centers) by a Provider licensed to perform dialysis.

Durable Medical Equipment
Durable Medicare Equipment is covered when provided by a Durable Medical Equipment Provider and determined by the Insured’s treating Physician to be Medically Necessary for the care and treatment of a Condition covered under this Group Plan. The specified Durable Medical Equipment will not, in whole or in part, serve as a comfort or convenience item for the Covered Employee or Covered Dependent or be available over-the-counter. Supplies and services to repair medical equipment may be a covered benefit only if the Covered Employee or Covered Dependent owns the equipment or is purchasing the equipment under a maintenance agreement with the Health Plan. The Health Plan’s Allowance for Durable Medical Equipment is based on the most cost-effective Durable Medical Equipment which meets the Covered Employee’s or Covered Dependent’s needs, as determined by the Health Plan. At the Health Plan’s option, the cost of either renting or purchasing will be covered. If the cost of renting is more than its purchase price, only the cost of the purchase is considered a Covered Service.

Repair or replacement of Durable Medical Equipment due to growth of a child or significant change in functional status is a Covered Service.

Emergency Services
Emergency Services for an Emergency Medical Condition are covered In-Network and Out-of-Network without the need for any Prior Authorization.

When Emergency Services for an Emergency Medical Condition are rendered by an Out-of-Network Provider, any Cost-Share amount applicable to In-Network Providers for Emergency Services will also apply to such Out-of-Network Provider.
Enteral/Parenteral and Oral Nutrition Therapy
Enteral and Parenteral Nutrition is covered when considered Medically Necessary by the Health Plan and authorized in advance. Oral nutrition prescribed by a Physician is covered for Covered Persons through the age of twenty-four (24) with inborn errors of metabolism or inherited metabolic diseases, which includes phenylketonuria (PKU). Oral nutrition therapy of any other kind, or when taken for any other reason, is not considered Medically Necessary. Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein. Coverage for enteral, parenteral, and/or oral nutrition and any related supplies is subject to the Calendar Year maximum benefit of $2,500.

Erectile Dysfunction Treatment
Erectile dysfunction treatment services are covered when deemed Medically Necessary and authorized in advance by the Health Plan. Erectile dysfunction drugs may be excluded under applicable Prescription Drug coverage.

Family Planning
Contraceptive counseling and contraceptive services approved by the U.S. Food and Drug Administration (FDA) and prescribed by a Physician are covered as preventive benefits, with the exception of items available over-the-counter that do not require a Physician Prescription. Covered contraception includes Physician-prescribed barrier methods, hormonal methods, implanted devices, and surgical methods (temporary and permanent). The drug Formulary lists which Prescription contraceptives are covered as preventive benefits under applicable Prescription Drug coverage.

Fitness Center Membership
Fitness center membership is covered to assist all Covered Persons with maintaining or improving their health status. The Health Plan offers a fitness center membership to Certificate Holders and their Covered Dependents exclusively at fitness centers contracted as Participating Providers. A Physician release may be required prior to accessing this benefit, and continued eligibility for this program is subject to separate rules of conduct as established by the Participating facilities. Membership to Pro Health and Fitness Centers is offered to members twelve (12) years of age and older. Age limitations may apply for other Participating fitness centers as well.

Genetic and Chromosomal Testing
Genetic and chromosomal testing is covered when considered Medically Necessary by the Health Plan and authorized in advance. In general, such testing is considered Medically Necessary when the test has proven analytical and clinical validity and the results are necessary for the immediate decision about treatment options for the member. When testing for inheritable diseases, the member must be at risk of carrier status (as supported by existing peer-reviewed, evidence-based, scientific literature) for the presence of a genetically-linked inheritable disease, with testing performed to possibly identify a specific genetic mutation that may impact clinical outcomes based on existing peer-reviewed, evidence-based, scientific literature. BRCA Analysis to determine a woman’s genetic risk for breast and ovarian cancer is covered as a preventive benefit when Medical Necessity criteria are met.

Home Health Care
The Home Health Care Services listed below are covered when all of the following criteria are met:
1. You are unable to leave your home without considerable effort and the assistance of another person because you are bedridden or chair bound, you are restricted in ambulation (whether or not you use assistive devices), or you are significantly limited in physical activities due to a Condition; and

2. The Home Health Care Services rendered have been prescribed by a Physician by way of a formal written treatment plan, which has been reviewed and renewed by the prescribing Physician at least every thirty (30) calendar days until benefits are exhausted (we reserve the right to request a copy of any written treatment plan in order to determine whether such services are covered under this Certificate); and

3. The Home Health Care Services are provided directly by (or indirectly through) a Home Health Agency; and

4. You are meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

Home Health Care Services are limited to:

1. A total of three (3) intermittent visits per day provided by a Participating Home Health Agency. One (1) visit equals a period of four (4) hours or less;

2. A total of sixty (60) visits per Calendar Year as set forth in the Schedule of Benefits;

3. Home health aide services which are consistent with the plan of treatment, ordered by a Physician, and rendered under the supervision of a Registered Nurse;

4. Medical social services;

5. Nutritional guidance;

6. Respiratory or inhalation therapy (e.g., oxygen);

7. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist; and

8. Supplies as needed to provide the covered care to the extent they would have been covered if under Hospital Confinement.

As needed, the Health Plan will review the Insured’s Condition and plan of care to assure that the above criteria are continuing to be met and that the services provided are both skilled and intermittent. Until such time as documentation is provided for review, and in lieu of hospitalization or continued hospitalization, services will be covered.

Hospice Services

Health Care Services provided when Hospice services are the most appropriate and cost-effective treatment in connection with a Hospice treatment program may be Covered Services provided the Hospice treatment program is approved by your Physician. Your Physician may be required to certify your life expectancy in writing. Coverage for Hospice services is limited to 180 days per Calendar Year as outlined in the Schedule of Benefits.

To qualify for coverage, the attending Physician must (1) certify that the patient is not expected to live more than one (1) year on a life expectancy certification and (2) submit a written Hospice Care plan or program. Certificate Holders or Covered Dependents who elect Hospice Care under this provision are not entitled to any other services under this plan for the terminal illness while the Hospice election is in effect. Under these circumstances, the following services are covered.

Home Hospice Care, comprised of:
1. Physician services and part-time or intermittent nursing care by a Registered Nurse or Licensed Practical Nurse;
2. Home health aides;
3. Inhalation (respiratory) therapy;
4. Medical social services;
5. Medical supplies, drugs and appliances;
6. Medical counseling for the terminally ill Certificate Holder or Covered Dependent; and
7. Physical, Occupational and Speech Therapy as deemed appropriate by the Health Plan.

Inpatient Hospice Care in a Hospice Facility, Hospital or Skilled Nursing Facility, if approved in writing by the Health Plan, includes care for pain control or acute chronic symptom management.

The Hospice treatment program must:

1. Meet the standards outlined by the National Hospice Association;
2. Be recognized as an approved Hospice program;
3. Be licensed, certified, and registered as required by Florida law; and
4. Be directed by a Physician and coordinated by a Registered Nurse, with a treatment plan that provides an organized system of Hospice Facility Care, uses a Hospice team, and has around-the-clock care available.

Health Care Services provided in connection with a Hospice treatment program may be Covered Services, provided the Hospice treatment program is:

1. Approved by your Physician; and
2. Your doctor has certified to us in writing that your life expectancy is twelve (12) months or less.

Recertification is required every six (6) months.

Hospital Services
The services and supplies listed below shall be considered Covered Services when furnished to an Insured at a Hospital on an Inpatient or outpatient basis in accordance with all other plan provisions included herein. Covered Services are subject to the Cost-Share, which may consist of Deductibles and Coinsurance, as noted in the Schedule of Benefits.

1. Room and board for semi-private accommodations, unless the patient must be isolated from others for documented clinical reasons;
2. Confinement in an intensive care unit, including cardiac, progressive, and neonatal care;
3. Covered Physician services provided while in an Inpatient setting;
4. Miscellaneous Hospital services;
5. Drugs and medicines administered by the Hospital;
6. Respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
7. Rehabilitative services, when hospitalization is not primarily for rehabilitation;
8. Use of operating room and recovery rooms;
9. Use of emergency rooms;
10. Intravenous solutions;
11. Administration and cost of whole blood or blood products (except as outlined in the Exclusions and Limitations section);
12. Dressings, including ordinary casts, splints and trusses;
13. Anesthetics and their administration;
14. Transfusion supplies and equipment;
15. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., electrocardiogram (EKG));
16. Imaging services, including CT scans, Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) scans, and Nuclear Cardiology Studies;
17. Outpatient observation;
18. Chemotherapy treatment for proven malignant disease;
19. Physical, Speech, Occupational and Cardiac Therapies;
20. Transplants, as described in the Transplant Services category of this section; and
21. Other Medically Necessary services and supplies.

Human Growth Hormone Therapy
Human growth hormone therapy services are covered as determined Medically Necessary by the Health Plan. For Group Plans with an attached Prescription Drug Rider, please see the Formulary for covered products.

Imaging Services
Covered imaging services include standard radiology services and advanced (high-end) imaging, including CT scans, Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET) scans, and Nuclear Studies. Advanced imaging requires Prior Authorization.

Immunizations
Immunizations, including flu shots, are covered when Medically Necessary and not listed as an exclusion. Immunizations recommended by the Centers for Disease Control and Prevention (CDC) for routine use in adults and children are covered as preventive benefits.

Insulin
Insulin coverage includes the needles and syringes needed for insulin administration. However, the Insured must have a Physician's Prescription for such supplies on record with the Pharmacy where the supplies are purchased.

Mammograms
Mammograms performed for breast cancer screening or diagnostic testing are covered. The Health Plan shall provide coverage for the following:

1. One (1) mammogram annually for any woman who is forty (40) years of age or older. This is considered a Preventive Health Service and is not subject to Cost-Share as set forth in the Schedule of Benefits.
2. A baseline mammogram for any woman who is between 35-40 years of age.
3. Additional screening mammograms for any woman who is at risk of breast cancer because of a personal or family history or because of having biopsy-proven benign breast disease (subject to Cost-Share).
4. Diagnostic mammograms for follow-up to a clinical or radiological abnormality (subject to Cost-Share).
Mastectomy Services
Breast cancer treatment, including treatment for physical complications relating to a Mastectomy (including lymphedemas), and outpatient postsurgical follow-up in accordance with prevailing medical standards, as determined by you and your attending Physician, are covered. Outpatient postsurgical follow-up care for Mastectomy services shall be covered when rendered by a Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or your home. The treating Physician, after consultation with you, may choose the appropriate setting.

Mental and Nervous Disorder Treatment
Expenses for the services and supplies listed below for the treatment of Mental and Nervous Disorders will be considered Covered Services if provided to the Insured by a Physician, Psychologist, or Mental Health Professional:

1. Inpatient Confinement or Partial Hospitalization in a Hospital or a Psychiatric Facility for the treatment of a Mental and Nervous Disorder if authorized in advance. If Partial Hospitalization services or a combination of Inpatient and Partial Hospitalization services are rendered, the total benefits paid for all such services combined will not exceed the benefit limits, if any, shown in the Schedule of Benefits. Two (2) days of Partial Hospitalization will count as one (1) day towards the Inpatient Mental and Nervous Disorder benefit. Partial Hospitalization services must be provided under the direction of a licensed Participating Physician.

2. Outpatient treatment provided by a licensed psychiatrist, Psychologist, and Mental Health Professionals, which includes clinical social workers, marriage and family therapists, or mental health counselors, for a Mental and Nervous Disorder, including diagnostic evaluation and psychiatric treatment, individual therapy, and group therapy.

Newborn Care
A Newborn child will be covered from the moment of birth, provided that the Newborn child is eligible for coverage and properly enrolled. Covered Services shall consist of coverage for Injury or Sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth.

Newborn Assessment:
An assessment of the Newborn child is covered, provided the services are rendered at a Hospital, the attending Physician’s office, a Birth Center, or in the home by a Physician, Midwife or Certified Nurse Midwife, and the performance of any necessary clinical tests and immunizations are within prevailing medical standards. These services are not subject to the Calendar Year Deductible.

Ambulance services are covered when necessary to transport the Newborn child to and from the nearest appropriate facility which is staffed and equipped to treat the Newborn child’s Condition, as determined by us and certified by the attending Physician as Medically Necessary to protect the health and safety of the Newborn child.

Obesity Treatment
Physician counseling and nutritional counseling for obesity management by Network Providers are covered.

Obstetrical and Maternity Care
Obstetrical and maternity care received on an Inpatient or outpatient basis is covered, including Medically Necessary prenatal and postnatal care of the mother and baby. Up to fifteen (15) prenatal office visits per Calendar Year are covered as a preventive benefit, in addition to preventive care and screenings for women that are provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). Prenatal preventive coverage does not extend to perinatology services. Perinatologist visits are subject to the Specialist office visit Cost-Share set forth in the Schedule of Benefits.

Up to two (2) routine maternity ultrasounds are covered without Prior Authorization with associated Cost-Sharing, as well as additional Medically Necessary ultrasounds for high-risk pregnancies. Authorization may be required for additional routine ultrasound exams.

Services of Certified Nurse Midwives and midwives licensed pursuant to Chapter 467 of the Florida State Statutes are covered in a Facility, including a Birth Center. Planned home births may be covered when the delivery is overseen by a Physician, Certified Nurse Midwife, or licensed Midwife with Prior Authorization by the Health Plan. Authorization will be considered for low-risk pregnancies that are expected to result in a normal labor and delivery when (a) the mother has signed an informed consent, (b) a written plan of action is in place that provides for immediate medical care if an emergency arises, and (c) a licensed obstetrician who has evaluated the expectant mother provides written approval. The Cost-Share for home births will be the same as the Cost-Share for an Inpatient Hospital delivery.

Post-delivery care benefits include coverage for a postpartum assessment and Newborn assessment and may be provided at the Hospital, at the attending Physician’s office, at outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. Coverage is provided for a physical assessment of the Newborn and mother, and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards.

Prepared childbirth classes are covered up to $75 per Calendar Year.

Orthotic Devices
Orthotic Devices, including braces and trusses for the leg, arm, neck and back, and special surgical corsets, are covered when prescribed by a Physician and designed and fitted by an Orthotist. Benefits may be provided for necessary replacement of an Orthotic Device which is owned by you when due to irreparable damage, wear, a change in your Condition, or when necessitated due to growth of a child. Payment for splints for the treatment of temporomandibular joint (TMJ) dysfunction is limited to one (1) splint in a six-month period, unless a more frequent replacement is determined by us to be Medically Necessary.

Osteoporosis Screening, Diagnosis, and Treatment
Screening, diagnosis, and treatment of osteoporosis for high-risk individuals are covered, and includes:

1. Estrogen-deficient individuals who are at clinical risk for osteoporosis;
2. Individuals who have vertebral abnormalities;
3. Individuals who are receiving long-term glucocorticoid (steroid) therapy; and
4. Individuals who have primary hyperparathyroidism and individuals who have a family history of osteoporosis.

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Osteoporosis screening for women sixty (60) years of age or older, or those at high-risk, is considered a Preventive Health Service and is not subject to Cost-Share as set forth in the Schedule of Benefits.

Oxygen
Covered oxygen services include the expenses for oxygen and rental of the equipment necessary to administer it. However, the Health Plan reserves the right to monitor a Covered Employee’s or Covered Dependent’s use of oxygen to assure its safe and medically appropriate use. Reimbursement is based on Medicare guidelines, which cap rental payments at thirty-six (36) months, allowing payment for contents and supplies afterwards. New rental equipment may be obtained after five (5) years.

Pain Management
Pain management services that are determined to be Medically Necessary are covered.

Pap Smears
Pap smears are covered as a preventive benefit when performed as recommended by the United States Preventive Services Task Force (USPSTF). Additional pap smears are covered as diagnostic laboratory tests when Medically Necessary.

Pathologist Services
Pathologist services that are provided on an Inpatient or outpatient basis are covered. These professional services are not covered when associated with automated clinical lab tests that do not require interpretation by the pathologist.

Pre-Admission Tests
Pre-admissions tests are covered when ordered or authorized by a Participating Physician. However, the following conditions must be met:

1. The admission to the Hospital or the scheduled outpatient surgery must be confirmed in writing by the Health Plan before the testing occurs.
2. The tests must be performed within seven (7) days before admission to the Hospital or the outpatient surgery center.
3. The tests are performed in a facility accepted by the Hospital in place of the same tests that would normally be done while Hospital confined.
4. The tests are not duplicated in the Hospital to confirm diagnosis.
5. The Covered Person is subsequently admitted to the Hospital or the outpatient surgery is performed, except if a Hospital bed is unavailable or because there is a change in the Covered Person’s Condition which would preclude performing the procedure.

Prescription Drugs (Outpatient)
Outpatient Prescription Drugs included in the plan’s Formulary are covered if a Prescription Drug Rider is attached to this Certificate. All other plan requirements, including Medical Necessity, must also be met for the Prescription Drugs to be a covered benefit. The Rider describes in detail the coverage provided therein, and the Health Plan retains the right to modify the Rider from time to time without notice.

Preventive Child Medical Services
Periodic Physician-delivered or Physician-supervised services from the moment of birth up to the 19th birthday are covered as follows:
1. Periodic examinations, which include a history, a physical examination, and a
developmental assessment and anticipatory guidance necessary to monitor the normal
growth and development of a child;
2. Oral and/or injectable immunizations; and
3. Laboratory tests normally performed for a well-child.

In order to be covered, services shall be provided in accordance with prevailing medical
standards consistent with the Recommendations for Preventive Pediatric Health Care of the
American Academy of Pediatrics, the U.S. Preventive Services Task Force, or the Advisory
Committee on Immunization Practices established under the Public Health Service Act.

This benefit is considered a Preventive Health Service if billed as such and may not be subject
to Cost-Share when rendered by a Participating Provider, as set forth in the Schedule of
Benefits.

Preventive Medical and Gynecological Services
The following preventive services are covered without Cost-Share when obtained from
Participating Providers according to current guidelines:

1. Services recommended by the United States Preventive Services Task Force (USPSTF)
   with a current rating of A or B;
2. Immunizations recommended by the Advisory Committee on Immunization Practices of
   the Centers for Disease Control and Prevention (CDC) for routine use in children,
   adolescents, and adults;
3. Preventive care and screenings for infants, children, and adolescents that are provided
   for in the comprehensive guidelines supported by the Health Resources and Services
   Administration (HRSA); and
4. Preventive care and screenings for women that are provided for in comprehensive
   guidelines supported by the HRSA.

A routine physical exam for adults and a routine gynecological exam for women are also
covered as preventive benefits once per Calendar Year, to include the evaluation and
management of the patient with an age and gender-appropriate history, examination, and
counseling, as well as ordering of laboratory or other diagnostic tests. Only those tests given an
A or B rating by the USPSTF will be covered as preventive services.

This benefit does not include exams required for travel, or those needed for school,
employment, insurance, or governmental licensing, or when required by law enforcement,
unless the service is within the scope of, and coinciding with, the annual physical exam.

Prosthetic Devices (External)
The following Prosthetic Devices are covered when pre-authorized by the Health Plan,
prescribed by a Physician and designed and fitted by a Prosthetist. Instruction and appropriate
services required for the Insured to properly use the item (such as attachment or insertion) are
covered. The Health Plan reserves the right to provide the most cost efficient and least
restrictive level of service or item that can safely and effectively be provided. Covered devices
include:
1. Artificial hands, arms, feet, legs and eyes, including permanent implanted lenses following cataract surgery, cardiac pacemakers, and Prosthetic Devices incident to a Mastectomy;
2. Appliances needed to effectively use artificial limbs or corrective braces;
3. Penile prosthesis; and
4. Wigs or cranial prosthesis when related to restoration after cancer or brain tumor treatment.

Covered Prosthetic Devices (except cardiac pacemakers and Prosthetic Devices incident to Mastectomy) are limited to the first such permanent prosthesis (including the first temporary prosthesis if it is determined to be necessary) prescribed for each specific Condition. Benefits may be provided for necessary replacement of a Prosthetic Device which is owned by you when due to irreparable damage, wear, or a change in your Condition, or when necessitated due to growth of a child.

Radiologist Services
Radiologist services are covered on an Inpatient or outpatient basis.

Rehabilitative Outpatient Therapy Services
Outpatient therapies described below are covered when provided to help a person get back or improve skills and functioning for daily living that have been lost or impaired due to illness, Injury, or disability. With the exception of cardiac and pulmonary rehabilitation, coverage is limited to twenty (20) hours of each type of therapy per Calendar Year for each Condition being treated. All therapy services must be considered Medically Necessary by the Health Plan and may require authorization in advance.

1. Physical Therapy (PT) provided by a Physician or Licensed Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a covered condition are covered.
2. Occupational Therapy (OT) provided by a Physician or Licensed Occupational Therapist for the purpose of aiding in the restoration of normal physical function lost due to a covered condition are covered.
3. Speech Therapy (ST) provided by a Physician or Licensed Speech Therapist to aid in the restoration of speech loss or reduce impairment of speech resulting from a covered condition are covered.
4. Cardiac Rehab – Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Rehabilitation, for the purpose of aiding in the restoration of optimal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery are covered. Coverage is limited to thirty-six (36) sessions per lifetime.
5. Pulmonary Rehab – Services provided under the supervision of a Physician, or an appropriate Provider trained for Pulmonary Rehab, for the purpose of reducing symptoms, optimizing function, and stabilizing restrictive or obstructive lung disease processes. Coverage is limited to thirty-six (36) sessions per lifetime.

Physical Therapy, Outpatient Therapy and Speech Therapy are covered only for conditions of new onset that interfere with normal activities of daily living. Visit limits for all outpatient therapies are dependent upon the nature and severity of the impairment. Ongoing therapy for chronic conditions is not a covered benefit. All therapy services must meet Medical Necessity criteria for short-term acute therapy.
Routine Costs Associated with Clinical Trials
Covered routine costs associated with clinical trials include items or services typically provided in absence of a clinical trial when provided or administered in a way considered standard for the condition being treated. Routine costs include expenses for items and services provided in either the experimental or control arm of a clinical trial that would otherwise be covered under the plan.

Routine costs associated with clinical trials may be covered:

1. When Insured eligibility requirements are met;
2. Subject to coverage provisions, limitations and exclusions;
3. When Prior Authorization is received for services that require authorization in advance;
4. When received from Participating Providers or Non-Participating Providers when required in order to participate in the trial. Coverage for items or services obtained from Non-Participating Providers is limited to the Health Plan’s Allowable Fee Schedule. Covered Persons covered under a HMO Group Plan must receive Prior Authorization from the Health Plan for services rendered by a Non-Participating Provider in order for the services to be covered.

The following are not considered routine costs and are not covered:

1. The investigational item or service itself. This includes items or services that would ordinarily be considered standard but are used in an experimental fashion.
2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
3. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.
4. Complications resulting from participation in a clinical trial.

Second Medical Opinions
Each Insured is entitled to request a second medical opinion by a Physician of his or her choice subject to the following conditions:

1. The Insured disagrees with a Physician’s opinion regarding the reasonableness or necessity of a surgical procedure, or the treatment is for a serious Injury or illness.
2. For Insureds enrolled in a HMO Group Plan, second opinions by Non-Participating Physicians must be authorized by the Health Plan in advance. If further diagnostic tests are required, the Health Plan reserves the right to require such testing to be performed In-Network. Out-of-Network services of any kind must be authorized by the Health Plan in advance.
3. The Insured will pay applicable Cost-Sharing amounts for a second opinion by a Participating Physician.
4. The Health Plan will pay 60% of the Allowed Amount for a second opinion by a Non-Participating Physician.
5. Only one (1) second opinion is covered for the condition being evaluated, unless the first two opinions substantially disagree. If the opinions disagree, a third opinion will be covered according to the provisions contained in this section.
6. A maximum of three (3) opinions may be covered for any one (1) condition in a Calendar Year. Additional opinions may be authorized at the sole discretion of the Health Plan.
7. The Insured’s Physician and the Health Plan’s Medical Director’s judgment concerning the treatment shall be controlling, after review of the second opinion, as to the obligations of the Health Plan.

Any treatment, including follow-up treatment pursuant to the second opinion, must be authorized by the Health Plan if Prior Authorization is required for the service.

**Self-Administered Prescriptions Drugs**
Self-administered Prescription Drugs are covered if a Prescription Drug Rider is attached to this Certificate. Such coverage only applies to those used in the treatment of diabetes, cancer, conditions requiring immediate stabilization (e.g., anaphylaxis), or in the administration of dialysis.

**Skilled Nursing Facilities**
Skilled Nursing Facility services are covered only if a written plan of treatment is submitted by a Physician and only if the Health Plan agrees that such skilled level services are being provided in lieu of hospitalization or continued hospitalization. The number of days covered is limited to 180 days per Calendar Year, as outlined in the Schedule of Benefits. The following Health Care Services may be Covered Services when you are an Inpatient in a Skilled Nursing Facility:

1. Room and board;
2. Respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
3. Drugs and medicines administered while an Inpatient (except take home Drugs);
4. Intravenous solutions;
5. Administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the Exclusions and Limitations section);
6. Dressings, including ordinary casts;
7. Transfusion supplies and equipment;
8. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
9. Chemotherapy treatment for proven malignant disease;
10. Physical, Speech, and Occupational Therapies; and
11. Other Medically Necessary services and supplies.

If an Insured is a resident of a continuing care facility certified under Chapter 651 of the Florida State Statute or a retirement facility consisting of a nursing home or assisted living facility, the Insured’s Primary Care Physician (PCP) must refer the Insured to that facility’s skilled nursing unit or assisted living facility if: (1) requested by the Insured and agreed to by the facility; (2) the PCP finds that such care is Medically Necessary; (3) the facility agrees to be reimbursed at the Health Plan’s contracted rate negotiated with similar Providers for the same services and supplies; and (4) the facility meets all guidelines established by the Health Plan related to quality of care, utilization, referral authorization, and other criteria applicable to Providers under contract for the same services. If the Health Plan enrolls a new Insured who already resides in a continuing care facility or assisted living facility as described herein, and that Insured’s request to reside in a skilled nursing unit or assisted living facility is denied, the Insured may use the Grievance Process outlined in the Complaint, Grievance and Appeal section of this Certificate.

**Sleep-Related Disorders Testing and Treatment**
Sleep-related disorder testing and treatment, including sleep studies, Positive Airway Pressure (PAP) devices, and sleeping agents listed in the plan’s Formulary for Group Plans with an
attached Prescription Drug Rider, is covered when Medically Necessary and authorized in advance when Prior Authorization is required.

**Smoking Cessation Programs**
Smoking cessation programs, including services or FDA-approved Prescription Drugs and supplies to eliminate or reduce the dependency on, or addiction to, tobacco, are covered.

**Spine and Back Disorder Chiropractic Treatment**
Services rendered by Physicians for manipulations of the spine to correct a slight dislocation of a bone or joint that is demonstrated by x-ray are covered. Payment guidelines for spinal manipulation are as follows:

1. Payment for covered spinal manipulation is limited to no more than twenty (20) spinal manipulations per Calendar Year.
2. Payment for covered Physical Therapy services rendered on the same day as spinal manipulation is limited to one (1) Physical Therapy treatment per day, not to exceed fifteen (15) minutes in length.

**Surgical Assistant Services**
Services are covered when rendered by a Physician, Registered Nurse First Assistant or Physician Assistant when acting as a surgical assistant (provided no inter, resident, or other staff Physician is available) when the assistant is necessary.

**Surgical Procedures**
Surgical procedures that are Medically Necessary and performed by a Physician on an Inpatient or outpatient basis may be covered, including the following:

1. Sterilization (tubal ligations and vasectomies), regardless of Medical Necessity. Sterilization services for women are covered as a preventive benefit. Vasectomies for men are covered as a preventive benefit when performed in a Physician office setting.
2. Surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes.
3. Oral surgical procedures for excisions of tumors, cysts, abscesses, and lesions of the mouth.
4. Surgical procedures involving bones or joints of the jaw (e.g., temporomandibular joint (TMJ)) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or Injury.
5. Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic services to help determine the need for surgery.

Payment guidelines for surgical procedures are as follows:

1. In accordance with American Medical Association (AMA) coding guidelines, payment for multiple surgical procedures performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on fifty (50) percent of the Allowed Amount for any secondary surgical procedure(s) performed and is subject to the Cost-Share amount (if any) indicated in your Schedule of Benefits. This guideline is applicable to all bilateral procedures and some surgical procedures performed on the same date of service.
2. Payment for incidental surgical procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An "incidental surgical procedure" includes surgery where one or more surgical procedures is performed through the same incision or operative approach as the primary surgical procedure which, in our opinion, is not clearly identified and/or does not add significant time or complexity to the surgical session. For example, the removal of a normal appendix performed in conjunction with a Medically Necessary hysterectomy is an incidental surgical procedure (i.e., there is no payment for the removal of the normal appendix in the example).

3. Payment for surgical procedures for fracture care, dislocation treatment, debridement, wound repair, Unna boot, and other related Health Care Services, is included in the Allowed Amount for the surgical procedure.

**Transplant Services**

Transplant services, limited to the procedures listed below, may be covered when performed at a facility acceptable to us and are subject to the conditions and limitations described below. Transplant includes pre-Transplant, Transplant and post-discharge services and treatment of complications after transplantation. We will pay benefits only for services, care and treatment received or provided in connection with the approved transplantation of the following human tissue or organs:

1. Cornea;
2. Heart;
3. Heart-lung combination;
4. Liver;
5. Kidney;
6. Lung-whole single or whole bilateral transplant;
7. Pancreas;
8. Pancreas Transplant performed simultaneously with a kidney Transplant; or
9. Bone Marrow Transplant, as defined in the Definitions section of this Certificate, when determined to be accepted within the appropriate oncological specialty and not experimental pursuant to FS 627.4236(3) (a). The Health Plan will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for the Insured and will be subject to the same limitations and exclusions as would be applicable to the Insured. Coverage for the reasonable expenses of searching for the donor will be limited to a search among immediate family members and donors identified though the National Bone Marrow Donor Program.

This Transplant benefit is subject to Prior Authorization requirements, and as such, the Insured or the Insured's Physician must notify the Health Plan in advance of the Insured's initial evaluation for the procedure in order for the Health Plan to determine if the Transplant services will be covered. For approval of the Transplant itself, the Health Plan must be given the opportunity to evaluate the clinical results of the evaluation. Such evaluation and approval will be based on written criteria. If approval is not obtained, benefits will not be provided for the Transplant procedure.

Once the Transplant procedure is approved, the Health Plan will advise the Insured's Physician of those facilities that have been approved for the type of Transplant procedure involved. Benefits are payable only if the pre-Transplant services, the Transplant procedure and post-discharge services are performed in an approved facility.
For approved Transplant procedures, and all related complications, the Health Plan will pay benefits only for the following covered expenses:

1. Hospital expenses and Physician's expenses will be paid under the Hospital services benefit and Physician services benefit in this Group Plan in accordance with the same terms and conditions as the Health Plan will pay benefits for care and treatment of any other covered Condition.
2. Transportation costs for the Insured to and from the approved facility where the Transplant is to be performed if the facility is more than one hundred (100) miles from the Insured's home.
3. Direct, non-medical costs for one (1) of the Insured's immediate family members (two family members if the patient is under age eighteen (18)) for: (a) transportation to and from the approved facility where the Transplant is performed, but no more than one (1) round trip per person, per Transplant and (b) temporary lodging at a prearranged location during the Insured's Confinement in the approved Transplant facility, not to exceed $75 per day. Direct, non-medical costs are only payable if the Insured lives more than one hundred (100) miles from the approved Transplant facility. There is a $5,000 maximum per Transplant for these direct, non-medical expenses.
4. Organ acquisition, donor costs and Bone Marrow Transplants as specifically outlined in this Certificate. However, donor costs are not payable under this Group Plan if they are payable in whole or in part by any other insurance health plan, organization or person other than the donor's family or estate.

**Vision Services**
Coverage includes the following services:

1. Physician services, soft lenses or sclera shells for the treatment of aphakic patients;
2. Initial glasses or contact lenses following cataract surgery; and
3. Physician services to treat an Injury to or disease of the eyes.

Additional coverage for vision services and materials may be covered if a Vision Rider is attached to this Certificate.

**Well Woman Annual Exam**
An annual well woman gynecological exam is covered at an obstetrician's/gynecologist's or Primary Care Physician’s office. This benefit is considered a Preventive Health Service if billed as such and may not be subject to Cost-Share when rendered by a Participating Provider as set forth in the Schedule of Benefits.

**V. EXCLUSIONS AND LIMITATIONS**

**A. ACCESS RULES**

If a Covered Person does not follow the rules for accessing services and supplies as described in this section, the Covered Person risks having the services and supplies received not covered by this Group Plan. In such a circumstance, the Covered Person would be responsible for the entire cost of the services rendered.

Services that are provided or received without having been prescribed, directed or authorized in advance by the Health Plan when required are not covered. Except for Emergency Services
and Care for an Emergency Medical Condition or Urgent Care, all services and supplies must be received from Participating Providers, unless covered under a Point-of-Service (POS) plan.

Services that, in the Health Plan's opinion, are not Medically Necessary will not be covered. The ordering of a service by a Physician, whether participating or non-participating, does not in itself make such service a Covered Service or Medically Necessary. Whether a service is a Covered Service is determined according to the terms of the Group Plan as solely interpreted by the Health Plan or its delegate.

B. HEALTH CARE SERVICES EXCLUSIONS

In addition to the access rule conditions noted above, the services and supplies listed in this section are excluded from coverage and are not Covered Services and supplies under this Group Plan.

Abortion
Abortion, including any service or supply related to an elective abortion, is excluded from coverage. However, spontaneous abortions are not excluded nor are abortions performed when the life of the mother would be endangered if the fetus were carried to term.

Alcohol or Drug-Related Injuries
Alcohol or drug-related Injuries, when sustained as a result of being under the influence of alcohol, an illegal substance, or a narcotic not taken upon the advice of a Physician, are excluded from coverage.

Alternative Medical Treatments
Alternative medical treatments, which include the following, are excluded from coverage:

1. Self-care or self-help training;
2. Homeopathic medicine and counseling;
3. Ayurvedic medicine, such as lifestyle modifications and purification therapies;
4. Traditional Oriental medicine, including acupuncture;
5. Massage therapy;
6. Naturopathic medicine;
7. Environmental medicine, including the field of clinical ecology;
8. Chelation therapy;
9. Thermography;
10. Mind-body interactions, such as meditation, imagery, yoga, dance, and art therapy;
11. Biofeedback services, except when considered Medically Necessary by the Health Plan and authorized in advance;
12. Prayer and mental healing;
13. Manual healing methods, such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, the Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics;
14. Reiki, SHEN therapy, and therapeutic touch;
15. Bioelectromagnetic applications in medicine; and
16. Herbal therapies.

Ambulance Services Provided Without Transfer
Ambulance services provided without transfer to a facility are not covered.
Anesthesia Administration Services
Anesthesia services by an operating Physician or his or her partner or associate are not covered. Refer to the Covered Services section of this Certificate for covered anesthesia administration services.

Applied Behavior Analysis (ABA) Services
ABA services for any condition are excluded from coverage.

Arch Supports
Shoe inserts designed to effect conformational changes in the foot or foot alignment; orthopedic shoes; over-the-counter, custom-made or built-up shoes; cast shoes; sneakers; ready-made compression hose or support hose; or similar type devices/appliances, regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease, are excluded from coverage.

Assisted Reproductive Therapy (Infertility)
Assisted reproductive therapy, includes associated services, supplies, and medications for In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT) procedures; Zygote Intrafallopian Transfer (ZIFT) procedures; Artificial Insemination (AI); embryo transport; surrogate parenting; donor semen and related costs, including collection and preparation; and infertility treatment medication, are excluded from coverage.

Autopsy or Postmortem Examination Services
Autopsy or postmortem examination services are excluded from coverage, unless specifically requested by the Health Plan.

Blood Fees
Blood fees associated with the collection, storage, or donation of blood or blood products are excluded from coverage, except for autologous donation in anticipation of scheduled services where, in the Health Plan’s opinion, the likelihood of excess blood loss is such that transfusion is expected adjunct to surgery.

Bloodless Surgery
Bloodless surgery is excluded from coverage, unless comparable outcomes, complication rates, and mortality rates are demonstrated through peer reviewed clinical studies when compared to standard surgical methods.

Breast Reduction Services
Breast reduction services are excluded from coverage.

Charges, Expenses, or Costs Applied Toward Satisfaction of any Applicable Deductible, Coinsurance, or Copayment Amounts
Such charges, expenses or costs are the Covered Person’s responsibility and are not covered by the Health Plan.

Charges, Expenses, or Costs in Excess of the Allowed Amount
For a Point-of-Service (POS) Insured receiving services or supplies from a Non-Participating Provider that has not entered into an agreement with the Health Plan to provide access at a discount from the billed amount of that Provider, charges, expenses or costs in excess of the
Health Plan’s Allowed Amount for Covered Services are the sole responsibility of the Insured and are excluded from coverage.

Charges Incurred Outside of the United States
Charges incurred outside of the United States are excluded from coverage if the Insured traveled to such location to obtain medical services, drugs, or supplies, or when such services, drugs or supplies are illegal in the United States.

Complications of Non-Covered Services
Complications of non-Covered Services, including the diagnosis or treatment of any condition which arises as a complication of a non-Covered Service (e.g., Health Care Services to treat complication of Cosmetic Surgery) are not covered.

Cosmetic Surgery
Plastic and Reconstructive Surgery and other services and supplies to improve the Insured’s appearance or self-perception (except as covered under the Breast Cancer Treatment category in the Covered Services section of this Certificate), which includes procedures or supplies to correct hair loss or the appearance of skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A) and hair implants/transplants, are excluded from coverage.

Costs Incurred by the Covered Person related to the following are excluded from coverage:

1. Health Care Services resulting from accidental bodily Injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense provision of any automobile insurance policy or liability policy.
2. Telephone consultations, failure to keep a scheduled appointment, or completion of any form and/or medical information.

Custodial Care
Custodial Care, including any service or supply of a custodial nature primarily intended to assist the Insured in the activities of daily living, is excluded from coverage. This exclusion includes rest homes, home health aides (sitters), home parents, domestic maid services, Respite Care and provision of services which are for the sole purpose of allowing a family member or caregiver of a Covered Person to return to work.

Dental Services
Dental treatment in a Hospital or Ambulatory Surgical Center, for children under age nineteen (19) due to cleft palate or cleft lip, or in preparation for radiation treatment, renal transplantation or heart valve replacement surgery are covered as specified in the Covered Services section. All other dental procedures are excluded from coverage, including extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment (including palatal expansion devices), bruxism appliances, dental x-rays and intra-oral surgical procedures.

Dental services related to the treatment of malocclusion or malposition of the teeth or jaws (orthognathic treatment), as well as temporomandibular joint (TMJ) syndrome or craniomandibular jaw disorders (CMJ) are also excluded. Non-dental treatments for these conditions may be covered if deemed Medically Necessary by the Health Plan.

Developmental Delay Treatment
Developmental delay treatment, including services and supplies necessary to improve the motor, language, social or thinking skills of a covered child who does not reach their developmental milestones at expected times, is excluded from coverage.

**Durable Medical Equipment**
Durable Medical Equipment (DME) items that are primarily for convenience and/or comfort; items available over-the-counter; wheelchair lifts or ramps; modifications to motor vehicles and/or homes, such as wheelchair lifts or ramps; water therapy devices, such as Jacuzzis, swimming pools, whirlpools or hot tubs; exercise and massage equipment; air conditioners and purifiers; humidifiers; water softeners and/or purifiers; pillows, mattresses or waterbeds; escalators; elevators; stair glides; emergency alert equipment; handrails and grab bars; heat appliances; dehumidifiers; and the replacement of equipment, unless it is non-functional and not practically repairable, are excluded from coverage.

Refer to the Covered Services section of this Certificate for covered DME items.

**Experimental and Investigational Treatment**
Experimental and Investigational Treatment, as defined in the Definitions section of this Certificate, is excluded from coverage. This exclusion does not include routine costs that would otherwise be covered if the Insured were not enrolled in a clinical trial, as well as services otherwise covered under the Bone Marrow Transplant provision of the Transplant Services category, both described in the Covered Services section of this Certificate.

**Failure to Follow Treatment**
Further care for a condition under treatment will not be covered if the Insured refuses to accept any treatment, procedure, or facility transfer recommended by the Health Plan.

**Food and Food Products**
Food and food products, including oral nutrition supplements, are excluded from coverage with the exception of those listed as Covered Services under the Enteral/Parenteral and Oral Nutrition Therapy category of the Covered Services section of this Certificate.

**Foot Care**
Routine foot care, including any service or supply in connection with foot care in the absence of disease, is excluded from coverage. Examples of foot care include non-surgical treatment of bunions, flat feet, fallen arches, and chronic foot strain, toenail trimming, corns, or calluses. This exclusion does not apply to services otherwise covered under the Diabetes Outpatient Self-Management category of the Covered Services section of this Certificate.

**Hearing Aids**
Hearing aids (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries and cost of repair, are excluded from coverage, unless coverage is provided for in a Hearing Care Rider attached to this Certificate.

**Home Health Care Services**
The following Home Health Care services are excluded from coverage:

1. Homemaker or domestic maid services;
2. Sitter or companion services;
3. Services rendered by an employee or operator of an adult congregate living facility, an adult foster home, an adult day care center, or a nursing home facility;
4. Custodial Care;
5. Food, housing, and home delivered meals; and
6. Services rendered in a Hospital, nursing home, or intermediate care facility.

If the Insured’s Condition does not warrant the services being provided, or if the services are custodial in nature, the services will be denied. Any services that would not have been covered had the Insured been confined in a Hospital are also excluded from coverage.

Refer to the Covered Services section of this Certificate for information on covered Home Health Care services.

**Hospice Services**
Covered Hospice services do not include bereavement counseling, pastoral counseling, financial or legal counseling, or Custodial Care. Refer to the Hospice Services category in the Covered Services section of this Certificate for information on covered Hospice services.

**Hospital Services**
The following Hospital services are excluded when such services could have been provided without admitting you to the Hospital: 1) room and board provided during the admission; 2) Physician visits provided while you were an Inpatient; 3) Occupational Therapy, Speech Therapy, Physical Therapy, and Cardiac Therapy; and 4) other services provided while you were an Inpatient.

In addition, expenses for the following and similar items are also excluded:

1. Gowns and slippers;
2. Shampoo, toothpaste, body lotions and hygiene packets;
3. Take-home drugs;
4. Telephone and television;
5. Guest meals or gourmet menus; and
6. Admissions kits.

Refer to the Covered Services section of this Certificate for information on covered Hospital services.

**Hypnotism or Hypnotic Anesthesia**
Hypnotism and hypnotic anesthesia are excluded from coverage.

**Immunizations and Physical Examinations**
Immunizations and physical examinations, when required for travel or when needed for school, employment, insurance, or governmental licensing, are excluded from coverage, except as such examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements.

**Infertility Treatment**
Infertility treatment, services and supplies, including infertility testing, treatment of infertility and diagnostic procedures to determine or correct the cause or reason for the inability to achieve conception or the inability to maintain a pregnancy, are excluded from coverage. This exclusion includes medications (includes clomiphene citrate (Clomid)), artificial insemination, In-Vitro Fertilization (IVF), ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, cryogenic, or other preservation techniques used in such or similar procedures.
Injectables
Self-injectable medications are excluded from coverage, except as specifically provided for in the plan’s Formulary under any applicable Prescription Drug Rider.

Learning and Developmental Services
Testing, therapy or treatment for reading and learning disabilities are excluded from coverage, with the exception of the Autism Spectrum Disorder category in the Covered Services section of this Certificate. Services or treatment for mental retardation or other mental services are not covered, unless determined to be Medically Necessary.

Massage Therapy
Massage therapy is excluded from coverage.

Mental Health Services and Supplies
The following mental health services are excluded from coverage:

1. Services and supplies rendered in connection with a Condition not classified in current versions of standard code sets, including the International Classification of Diseases Clinical Modification (ICD CM) or the most recently published version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause or effect of the disorder;
2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or for mental retardation;
3. Services extended beyond the period necessary for evaluation and diagnosis of learning and disabilities or for mental retardation;
4. Services for marriage and juvenile counseling when not rendered in connection with a Condition classified in current versions of standard code sets, including the International Classification of Diseases, Clinical Modification (ICD- CM) or the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause or effect of the disorder;
5. Services for pre-marital counseling;
6. Services for court-ordered care or testing or required as a condition of parole or probation;
7. Services for testing of aptitude, ability, intelligence or interest;
8. Services for testing and evaluation for the purpose of maintaining employment;
9. Services for cognitive remediation;
10. Inpatient confinements that are primarily intended as a change of environment; and
11. Inpatient (over-night) mental health services received in a residential treatment facility.

Refer to the Covered Services section of this Certificate for information on covered mental health services.

Military Facility Services
Services that are eligible for coverage by the United States government, as well as any military service-connected care for which the Insured is legally entitled to receive from military or government facilities when such facilities are reasonably accessible to the Insured are excluded from coverage.

Missed Appointment Charges
Charges incurred by the Insured as a result of missed appointments are excluded from coverage.

**Non-Medically Necessary Services**
Non-Medically Necessary services are excluded from coverage, and include those services and supplies:

1. Which are not Medically Necessary, as determined by the Health Plan, for the diagnosis and treatment of illness, Injury, restoration of physiological functions;
2. That do not require the technical skills of a medical, mental health or a dental professional;
3. Furnished mainly for the personal comfort or convenience of the Insured, or any person who cares for the Insured, or any person who is part of the Insured’s family, or any Provider;
4. Furnished solely because the Insured is an Inpatient on any day in which the Insured’s disease or Injury could safely and adequately be diagnosed or treated while not confined;
5. Furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician’s or a dentist’s office or other less costly setting.

**Non-Participating Provider Services for HMO Covered Persons**
For an Insured covered under a HMO plan, services and supplies rendered or provided by Non-Participating Providers are excluded from coverage, unless authorized in advance by the Health Plan or for Emergency Services or Urgent Care.

**Non-Prescription Drugs**
Non-Prescription Drugs, including any vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods which are not included in the plan’s Formulary, are excluded from coverage.

**Nutritional Foods**
Nutritional foods, except as listed in the Covered Services section of this Certificate, are excluded from coverage.

**Obesity Procedures**
Bariatric surgery and medical procedures for the treatment of morbid obesity is excluded from coverage. This exclusion does not include services described in the Obesity Treatment category of the Covered Services section of this Certificate.

**Occupational Injury**
Expenses in connection with any condition for which an Insured has received, or is entitled to receive (whether by settlement or by adjudication), any benefit under Workers’ Compensation, Occupational Disease Law or similar law are excluded from coverage. If the Insured enters into a settlement giving up rights to recover past or future medical benefits, this Health Plan will not cover past or future medical services that are subject of or related to that settlement. In addition, if the Insured is covered by a Workers’ Compensation program that limits benefits if other than specified Health Care Providers are used, and the Insured receives care or services from a Health Care Provider not specified by the program, the Health Plan will not cover the balance of any costs remaining after the program has paid.

**Oral Surgery**
Oral surgery is excluded from coverage, except as provided for under the Covered Services section of this Certificate.
Organ Donor Treatment and Services
Organ donor treatment and services, when the Insured acts as the donor, are excluded from coverage. Organ screening and testing for possible match/compatibility are not covered, except as specifically covered for bone marrow donors as described in the Covered Services section of this Certificate.

Orthomolecular Therapy
Orthomolecular therapy, including nutrients, vitamins, and food supplements, is excluded from coverage.

Orthotic Devices
The following expenses are excluded from coverage:

1. Expenses for arch supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, heel inserts, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances, regardless of intended use, except for therapeutic shoes (including inserts and/or modification) for the treatment of diabetics with severe vascular disease, deformities or foot infections;
2. Expenses for orthotic appliances or devices which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding (e.g. dynamic orthotic cranioplasty or molding helmets), except when the orthotic appliance or device is used as an alternative to an internal fixation device as a result of surgery for craniosynostosis; and
3. Expenses for devices necessary to exercise, train, or participate in sports (e.g. custom-made knee braces).

Oversight of a Medical Laboratory by a Physician or Other Health Care Provider
"Oversight", as used in this exclusion, shall include, but not be limited to, the oversight of:

1. The laboratory to assure timeliness, reliability, and/or usefulness of test results;
2. The calibration of laboratory machines or testing of laboratory equipment;
3. The preparation, review or updating of any protocol or procedure created or reviewed by a Physician or other Health Care Provider in connection with the operation of the laboratory; and
4. The laboratory equipment or laboratory personnel for any reason.

Over-the-Counter Items
Supplies that can be obtained without a Prescription are excluded from coverage. Examples of these supplies include ace bandages, elastic stockings, gauze and dressings.

Personal Comfort, Hygiene or Convenience Items and Services
Personal comfort, hygiene or convenience items and services deemed to be not Medically Necessary and not directly related to the treatment of the Covered Person are excluded from coverage. This exclusion includes:

1. Beauty and barber services;
2. Clothing, including support hose;
3. Radio and television;
4. Guest meals and accommodations;
5. Telephone charges;
6. Take-home supplies,
7. Travel expenses (other than Medically Necessary Ambulance services);
8. Motel/hotel accommodations;
9. Air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting;
10. Hot tubs, Jacuzzis, heated spas or pools;
11. Heating pads, hot water bottles or ice packs;
12. Physical fitness equipment;
13. Hand rails and grab bars; and

Prescription Drugs
Prescription Drugs, including any outpatient Prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods, are excluded from coverage, unless a Prescription Drug Rider is attached to this Certificate. When applicable, the Rider will describe in detail the coverage provided therein, and the Health Plan retains the right to modify the Rider from time to time without notice.

Private Duty Nursing Care
Private duty nursing care is excluded from coverage, except as related to and set forth in the Home Health Care Services category of the Covered Services section of this Certificate.

Prosthetic Devices (External)
The following Prosthetic Device expenses are excluded from coverage:

1. Expenses for microprocessor controlled or myoelectric artificial limbs (e.g., C-legs); and
2. Expenses for cosmetic enhancements to artificial limbs.

Residential Treatment Facility Services
Any Inpatient or outpatient services provided in a residential treatment facility are excluded from coverage.

Services, Supplies, Treatment and Prescription Drugs that are:

1. Determined to be not Medically Necessary.
2. Not appropriately documented and/or substantiated in a corresponding medical record.
3. Not specifically listed in the Covered Services section of this Certificate, unless such services are specifically required to be covered by federal law.
4. Court-ordered care or treatment, unless otherwise covered under this Group Plan.
5. For the treatment of a condition resulting from:
   a. War or an act of war, whether declared or not;
   b. Participation in any act which would constitute a riot or rebellion, or a crime punishable as a felony;
   c. The Insured committing or attempting to commit a felony or from the Insured engaging in an illegal occupation;
   d. Services in the armed forces.
6. Received prior to an Insured's Effective Date or received on or after the date an Insured's coverage terminates under this Group Plan, unless coverage is extended in
accordance with the Extension of Benefits provision in the Administrative Provisions section of this Certificate.

7. Provided by a Physician or other Health Care Provider related to the Insured by blood or marriage.

8. Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.

9. Non-medical conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or Inpatient Confinement for environmental change.

10. Supplied at no charge when health coverage is not present, such as replaced blood, including whole blood, blood plasma, blood components, and blood derivatives.

**Sexual Reassignment or Modification Services**
Sexual reassignment and modification services are excluded from coverage, and include any service or supply related to such treatment, including psychiatric services and Prescription Drugs.

**Skilled Nursing Facilities**
Skilled Nursing Facility care is excluded when expenses are for an Inpatient admission to a Skilled Nursing Facility for purposes of Custodial Care, convalescent care, or any other service primarily for your convenience, that of your family members, and/or the Provider. Expenses for any Inpatient days beyond the per person maximum listed on your Schedule of Benefits are also excluded.

Refer to the Covered Services section of this Certificate for information on covered Skilled Nursing Facility care.

**Sports-Related Devices and Services**
Devices and services used to affect performance primarily in sports-related activities are excluded from coverage. All expenses related to physical conditioning programs, such as athletic training, body building, exercise, fitness, flexibility, and diversion or general motivation are also excluded.

**Sterility Reversal**
Reversal of voluntary, surgically-induced sterility, including the reversal of tubal ligations and vasectomies, is excluded from coverage.

**Therapy Services**
Therapy services provided on an Inpatient or outpatient basis, including Cardiac, pulmonary, Speech, Occupational and Physical Therapy, except as set forth in the Covered Services section of this Certificate, are excluded from coverage. This exclusion includes any service or supply intended to enhance or improve athletic or work performance unrelated to functional impairment.

**Training and Educational Programs**
Training and educational programs and materials, which include programs or materials for Pain Management, vision training or vocational rehabilitation, except as provided for under the Diabetes Outpatient Self-Management and Maternity categories of the Covered Services section of this Certificate, are excluded from coverage.

**Transplantation or Implantation Services and Supplies**
Transplantation and implantation services and supplies, including the Transplant or implant, other than those specifically listed in the Covered Services section of this Certificate, are excluded from coverage. This exclusion includes:

1. Any service or supply in connection with the implant of an artificial organ.
2. Any organ that is sold rather than donated to the Insured.
3. Any service or supply relating to any evaluation, treatment, or therapy involving the use of high-dose chemotherapy and autologous Bone Marrow Transplantation, autologous peripheral stem cell rescue, or autologous stem rescue for the treatment of any condition that is considered experimental based on rules established by the Florida Agency for Health Care Administration pursuant to F.S. 627.4236(3)(a).
4. Any service or supply in connection with identification of a donor from a local, state or national listing, except as specifically set forth for bone marrow donors in the Covered Services section of this Certificate.

Benefits are also not payable for, or in connection with, a Transplant if:

1. The Health Plan is not contacted for authorization prior to referral for Transplant evaluation of the procedure.
2. The Health Plan does not approve coverage for the procedure.
3. The Transplant procedure is performed in a facility that has not been designated by the Health Plan as an approved Transplant facility.
4. The expenses are eligible to be paid under any private or public research fund, government program, or other funding program, whether or not such funding was applied for or received.
5. The expenses are related to the transplantation of any non-human organ or tissue.
6. The expenses are related to the donation or acquisition of an organ for a recipient who is not covered by the Health Plan, except as specifically covered herein for Bone Marrow Transplants only.
7. A denied Transplant that is performed. This includes follow-up care, immunosuppressive drugs, and complications of such Transplant.
8. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in Rule 59B-127.001 of the Florida Administrative Code or any successor or similar rule or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare & Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual.
9. Any service in connection with identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant.

The following services/supplies/expenses are also not covered:

1. Artificial heart devices.
2. Drugs used in connection with diagnosis or treatment leading to a Transplant when such drugs have not received U.S. Food and Drug Administration (FDA) approval for such use.
3. Transplant expenses that are not authorized in advance by the Health Plan.

Transportation Services
Transportation services that are non-emergent and not covered by Medicare are excluded from coverage.

Travel and Vacation Expenses
Travel and vacation expenses, even if prescribed or ordered by a Provider, are excluded from coverage.

**Vision Services and Supplies**

Health Care Services to diagnose or treat vision problems that are not direct consequences of trauma or prior ophthalmic surgery, eye examinations, eye exercise or visual training, eye glasses, and contact lenses and their fittings are not covered. In addition, any surgical procedure performed primarily to correct or improve myopia (near sightedness), hyperopia (farsightedness), astigmatism (blurring), or exams for the correction of vision, and radial keratotomy eye surgery, including visual acuity improvements and related procedures to correct refractive errors, are excluded from coverage.

This exclusion does not include services described in the Vision Services category of the Covered Services section of this Certificate or vision services or materials that may be covered under an attached Vision Rider. When applicable, the Rider will describe in detail the coverage provided therein, and the Health Plan retains the right to modify the Rider from time to time without notice.

**Volunteer Services**

Volunteer services, or services that would normally be provided free of charge, and any charges associated with Deductible, Coinsurance, or Copayment requirements (if applicable) that are waived by a Health Care Provider, are excluded from coverage.

**Weight Control Services**

Weight control services, except for physician counseling services, are excluded from coverage. Examples of weight control services include weight control/loss programs, dietary regimens, food or food supplements, exercise programs, exercise or other equipment, gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict your ability to assimilate food.

**Wigs or Cranial Prosthesis**

Wigs and cranial prosthesis, except when related to restoration after cancer or brain tumor treatment, are excluded from coverage.

**Work-Related Condition Services**

Work-related condition services, to treat a work related Condition to the extent the Covered Service is paid by Workers’ Compensation through adjudication or settlement, or when the services would otherwise be eligible for coverage by Workers’ Compensation insurance, but were not claimed, are excluded from coverage.

**C. GENERAL EXCLUSIONS**

General exclusions include:

1. Any Health Care Service received prior to your Effective Date or after the date your coverage terminates;

2. Any Health Care Service not within the Covered Services categories described in the Covered Services section of this Certificate, any Rider or Endorsement attached hereto, unless such services are specifically required to be covered by applicable law;
3. Any Health Care Service provided by a Physician or other Health Care Provider related to you by blood or marriage;

4. Any Health Care Service which is not Medically Necessary as defined in this Certificate and determined by us. The ordering of a service by a Health Care Provider does not, in itself, make such service Medically Necessary or a Covered Service;

5. Any Health Care Service rendered at no charge;

6. Any Health Care Service to diagnose or treat any condition which initially occurred while you were (or which, directly or indirectly, resulted from, or is in connection with, you being) under the influence of alcoholic beverages, any chemical substance set forth in Section 877.111 of the Florida Statutes, or any substance controlled under Chapter 893 of the Florida Statutes (or, with respect to such statutory provisions, any successor statutory provisions). Notwithstanding, this exclusion shall not apply to the use of any Prescription medication by you if such medication is taken on the specific advice of a Physician in a manner consistent with such advice;

7. Any Health Care Service to diagnose or treat a condition which, directly or indirectly, resulted from or is in connection with:
   a. war or an act of war, whether declared or not;
   b. your participation in, or commission of, any act punishable by law as a misdemeanor or felony whether or not you are charged or convicted, or which constitutes riot or rebellion;
   c. your engaging in an illegal occupation;
   d. services received at military or government facilities;
   e. services received to treat a condition arising out of your service in the armed forces, reserves and/or National Guard;
   f. you being under the influence of alcohol or any narcotic, unless taken on the specific advice of a Physician in a manner consistent with such advice;
   g. an intentionally self-inflicted condition, suicide or attempted suicide, whether you are sane or insane; or
   h. services that are not patient-specific, as determined solely by us.

8. Health Care Services rendered because they were ordered by a court, unless such services are Covered Services under this Certificate; and

9. Any Health Care Service rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.

D. ADDITIONAL EXCLUSIONS AND LIMITATIONS FOR POINT-OF-SERVICE (POS) GROUP PLANS

1. Services and supplies that are not Medically Necessary are not covered, except for preventive services and care as outlined in the Covered Services section of this Certificate.

2. When services and supplies are received from Non-Participating Providers, charges in excess of the Allowable Fee Schedule are the sole responsibility of the Insured.
VI. UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

This section explains what your share of the Health Care Expenses will be for Covered Services you receive. In addition to the information explained in this section, it is important that you refer to your Schedule of Benefits to determine your share of the cost with regard to Covered Services.

A. THE CALENDAR YEAR DEDUCTIBLE

A Deductible is a specific annual dollar amount that you must pay for covered benefits received each Calendar Year. This amount, when applicable, must be satisfied by you each Calendar Year before any benefits subject to the Deductible are payable by us. Only those charges indicated on claims we receive for Covered Services will be credited toward the Calendar Year Deductible and only up to the Allowed Amount. Covered Services that are subject to the Calendar Year Deductible under this Group Plan are shown in the Schedule of Benefits.

The following out-of-pocket expenses will not count towards satisfying the Calendar Year Deductible requirement:

1. Expenses related to charges for services not covered by this Group Plan,
2. Any charges in excess of the Allowed Amount,
3. Expenses that relate to services that exceed specific treatment limitations explained in the Covered Services section of this Certificate or noted in the Schedule of Benefits, and
4. Prescription Drug expenses, unless the Group Plan includes integrated Prescription Drug coverage. (Note: Your Prescription Drug Rider may include a separate Prescription Drug Deductible that must be satisfied each Calendar Year. If applicable, this separate Deductible will be stated on the Rider attached to this Certificate.)

INDIVIDUAL CALENDAR YEAR DEDUCTIBLE

This amount, when applicable, must be satisfied by each Covered Person every Calendar Year before any payment will be made by the Health Plan for benefits subject to the Deductible. If you meet your individual Deductible, then Covered benefits subject to that Deductible are covered for you by the Health Plan for the remainder of the Calendar Year. Only those charges indicated on claims we receive for Covered Services will be credited toward the individual Calendar Year Deductible and only up to the Allowed Amount.

Note: If you have family coverage under a qualifying High Deductible Health Plan (Health Savings Account compatible), the individual Calendar Year Deductible is not applicable. Rather, the family Calendar Year Deductible must be satisfied, as described below, before any payment will be made by the Health Plan for benefits subject to the Deductible.

FAMILY CALENDAR YEAR DEDUCTIBLE

If you have family coverage (i.e. coverage for a Certificate Holder and one or more Covered Dependents under this Certificate), your plan includes a family Calendar Year Deductible. If you
are not covered by a qualifying High Deductible Health Plan (Health Savings Account compatible) with a family Deductible, your Deductible can be satisfied in one of two ways:

1. If you meet your individual Deductible, then covered benefits that are subject to that Deductible are covered for you by the Health Plan for the remainder of the Calendar Year.

2. If any number of Covered Persons in your family collectively meet the family Deductible, then covered benefits that are subject to the Deductible are covered for you and all Covered Dependents by the Health Plan for the remainder of the Calendar Year.

The maximum amount that any one Covered Person in your family can contribute toward the family Calendar Year Deductible is the amount applied toward the individual Calendar Year Deductible.

If you are covered by a qualifying High Deductible Health Plan (Health Savings Account compatible), you are not subject to an embedded individual Deductible as described above for covered family units. Instead, your family must meet the combined family Deductible prior to the Health Plan paying a portion towards the cost of Covered Services for any family member.

Calendar Year Deductible credit is extended to newly enrolled Covered Persons. Credit will be given for any portion of a Deductible satisfied under the prior carrier in the current Calendar Year, up to the Deductible of the new plan. Evidence supporting the credit amount must be supplied. Acceptable evidence may be in the form of an official company Explanation of Benefits statement.

Note: The Out-of-Network Calendar Year Deductible shown on your Schedule of Benefits is separate from your In-Network Deductible. Expenses applied toward your Out-of-Network Deductible do not get applied to your In-Network Deductible. Expenses applied toward your In-Network Deductible are not applied to your Out-of-Network Deductible.

B. COPAYMENTS

For some Covered Services, you are responsible for paying a flat dollar amount. This dollar amount is referred to as a Copayment. Copayments are due at the time of service. The Health Plan is not responsible for the coordination and collection of Copayments. The Provider is responsible for the collection of Copayments at the time services are rendered. The Copayment requirements for this Group Plan are set forth in the Schedule of Benefits and will apply in full, regardless of the amount of the actual charges. Listed below is a brief description of some of the Copayment requirements that may apply under your Group Plan.

OFFICE SERVICES COPAYMENT

Services provided by a Physician or other qualified Health Care Provider in an office setting are covered as indicated in the Schedule of Benefits. Office visit services may include the provision of evaluation and management (E/M) services, preventive care, immunizations, injections, diagnostic services, minor surgery, and certain therapy services. An office visit Copayment may apply when an E/M service is provided, or when an E/M service is not provided but a non-diagnostic procedure is performed that does not have a specific Cost-Share requirement. Additional Cost-Sharing may apply to other services provided during an office visit, such as diagnostic tests, medications, allergy services, and therapy services.
INPATIENT FACILITY SERVICES COPAYMENT

The Copayment for Inpatient facility services, if applicable to your Group Plan, must be satisfied by you for each Inpatient admission to a Hospital or Psychiatric Facility before any payment will be made by us for any claim for Inpatient Covered Services, unless specifically stated otherwise on your Schedule of Benefits. The Copayment for Inpatient facility services, if applicable to your Group Plan, applies, regardless of the reason for the admission, and applies to all Inpatient admissions to a Hospital or Psychiatric Facility.

Note: Copayments for Inpatient Facility services may vary depending on the facility chosen. Please see your Schedule of Benefits for more information.

OUTPATIENT FACILITY SERVICES COPAYMENT

The Copayment for outpatient facility services, if applicable to your Group Plan, must be satisfied by you and applies, regardless of the reason for the visit, for each outpatient visit to a Hospital or Ambulatory Surgical Center before any payment will be made by us for any claim for outpatient Covered Services. Cost-Share for additional services provided during the visit or stay may apply.

Note: Copayments for outpatient facility services may vary depending on the facility chosen and the services received. Please see your Schedule of Benefits for more information.

EMERGENCY ROOM FACILITY SERVICES COPAYMENT

The Copayment for emergency room facility services, if applicable to your Group Plan, applies, regardless of the reason for the visit, is in addition to any applicable advanced imaging Cost-Share, and applies to emergency room facility services within or outside the Service Area. The Copayment for emergency room facility services, if applicable to your Group Plan, must be satisfied by you for each visit, unless specifically stated otherwise on your Schedule of Benefits. If you are admitted to the Hospital as an Inpatient at the time of the emergency room visit, the Copayment for emergency room facility services, if applicable to your Group Plan, will be waived, but you will still be responsible for your share of the expenses for Inpatient facility services as listed in your Schedule of Benefits.

C. THE COINSURANCE PERCENTAGE

After satisfaction of the Calendar Year Deductible, you may be responsible for paying a percentage of the Allowed Amount for Covered Services. This percentage that you are responsible for is called the Coinsurance Percentage. The Coinsurance Percentage for this Group Plan is shown in the Schedule of Benefits.

When charges are incurred for Covered Services or supplies provided by Participating Providers, this Group Plan calculates all Coinsurance amounts by applying the Coinsurance Percentage to the amount the Participating Provider has agreed to accept for that service or supply in the negotiated fee schedule. If you are covered under a Point-of-Service (POS) plan and decide to utilize or seek care from Non-Participating Providers, you may incur additional financial fees associated with charges in excess of the Allowed Amount.

D. THE OUT-OF-POCKET MAXIMUM EXPENSE LIMIT
The Out-of-Pocket Maximum Expense Limit, as set forth in the Schedule of Benefits, is the maximum amount of expenses that you must pay in a Calendar Year before this Group Plan pays Covered Services at 100% of the Allowance determination for the remainder of that Calendar Year. All Cost-Sharing for Covered Services, including the Calendar Year Deductible, Copayment and Coinsurance amounts, contribute toward the Out-of-Pocket Maximum Expense Limit. Cost-Sharing for Covered Prescription Drugs incurred under the Group Plan’s Prescription Drug Rider, if applicable, will also contribute toward the Out-of-Pocket Maximum Expense Limit. Once the Out-of-Pocket Maximum Expense Limit is satisfied, this Group Plan pays 100% of the Allowance determination for Covered Services and Covered Prescription Drugs for the remainder of that Calendar Year. Unless your Prescription Drug coverage includes a separate Out-of-Pocket Maximum Expense Limit, the Out-of-Pocket Expense Limit set forth on your Schedule of Benefits will apply to both covered medical services and covered Prescription Drugs.

The following out-of-pocket expenses will not count towards satisfying the Out-of-Pocket Maximum Expense Limit:

1. Expenses related to charges for services and Prescription Drugs not covered by this Group Plan,
2. Any charges in excess of the Allowed Amount, and
3. Expenses that relate to services that exceed specific treatment limitations explained in the Covered Services section of this Certificate or noted in the Schedule of Benefits.

The application of any specific service limits or specific benefit maximums noted in the Covered Services section of this Certificate or in the Schedule of Benefits is not affected by satisfaction of the Out-of-Pocket Maximum Expense Limit. These specific service provisions will still apply after the Out-of-Pocket Maximum Expense Limit is satisfied.

INDIVIDUAL OUT-OF-POCKET CALENDAR YEAR MAXIMUM

Once you have reached the individual Out-of-Pocket Calendar Year Maximum Expense Limit listed in your Schedule of Benefits, you will have no additional out-of-pocket responsibility for the remainder of that Calendar Year for Covered Services, and we will pay 100% of the Allowed Amount for Covered Services rendered during the remainder of that Calendar Year.

FAMILY OUT-OF-POCKET CALENDAR YEAR MAXIMUM

If you have family coverage (i.e. coverage for a Certificate Holder and one or more Covered Dependents under this Certificate), your plan includes a family Out-of-Pocket Calendar Year Maximum. Your Deductible can be satisfied in one of two ways:

1. If you meet your individual Out-of-Pocket Maximum Expense Limit, then covered benefits will be paid by the Health Plan at 100% of the Allowed Amount for you for the remainder of the Calendar Year.
2. If any number of Covered Persons in your family collectively meets the family Out-of-Pocket Maximum Expense Limit, then covered benefits will be paid by the Health Plan...
at 100% of the Allowed Amount for you and all Covered Dependents for the remainder of the Calendar Year.

The maximum amount any one Covered Person in your family can contribute toward the family Out-of-Pocket Calendar Year Maximum is the amount applied toward the individual Out-of-Pocket Calendar Year Maximum.

**Note:** In-Network out-of-pocket expenses do not accumulate towards the Out-of-Network Out-of-Pocket Maximum Expense Limit shown in the Schedule of Benefits. Out-of-Network out-of-pocket expenses do not accumulate toward the In-Network Out-of-Pocket Maximum Expense Limit shown in the Schedule of Benefits.

We have the right to request for you to verify that you have reached your Out-of-Pocket Calendar Year Maximum Expense Limit by submitting receipts for sums actually paid. Thereafter, the appropriate party will reimburse you for any additional Cost-Share made during the Calendar Year in which the Out-of-Pocket Maximum Expense Limit had been met. You must submit receipts to us within sixty (60) days from the end of the Calendar Year in which the Out-of-Pocket Maximum Expense Limit had been met. You may call our Customer Service Department for information on Out-of-Pocket Maximum Expense Limits.

**E. ADDITIONAL EXPENSES YOU MUST PAY**

In addition to your share of the expenses described above, you are also responsible for:

1. Expenses incurred for non-Covered Services;
2. Charges in excess of any maximum benefit limitation listed in your Schedule of Benefits (e.g., the Calendar Year maximums);
3. For individuals covered under a POS plan, charges in excess of the Allowed Amount for Covered Services rendered by Providers who have not agreed to accept our Allowed Amount as payment in full;
4. Any benefit reductions;
5. Payment of expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage; and
6. Charges for Health Care Services or Prescription Drugs which are excluded.

**VII. CLAIM PROVISIONS**

A claim is any request for a Plan benefit or benefits made in accordance with the claim procedures described herein. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures.

**A. REIMBURSEMENT FOR PARTICIPATING AND NON-PARTICIPATING PROVIDER SERVICES**
The Health Plan will provide or arrange for Covered Services to be received from Participating Providers through a contractual arrangement. If an Insured receives Covered Services from a Participating Provider (as published in the Provider Directory), the Health Plan will pay the Health Care Provider directly for all care received. The Insured will not have to submit a claim for payment and will be responsible only for any applicable Deductibles, Copayments or Coinsurance.

In the event the Insured receives Emergency Services or Care from a Non-Participating Provider that has not entered into an agreement with the Health Plan to provide access at a discount from the billed amount of that Provider, payment shall be the lesser of:

1. The Provider’s charges;
2. The usual and customary Provider charges for similar services in the community where the services were provided; or
3. The charge mutually agreed to by the Health Plan and the Provider within sixty (60) days of the submittal of the Claim.

Such payment shall be the net of any applicable Cost-Share.

In the event a Point-of-Service (POS) Insured receives non-Emergency Services or Care from a Non-Participating Provider that has not entered into an agreement with the Health Plan to provide access at a discount from the billed amount of that Provider, the Insured will be reimbursed for the cost of the service at the Health Plan’s Allowable Fee Schedule, less applicable Cost-Share amounts. The Point-of-Service (POS) Insured will also be responsible for any balance between the Provider’s charges and the Health Plan’s Allowable Fee Schedule. This balance may be substantial. Notwithstanding the provisions in this section, the Health Plan is entitled to reimbursement from the subscriber in accordance with Section 768.76(4) F.S. or the decision of a court of competent jurisdiction.

The following provisions apply in the event the Insured needs to file a claim for Non-Participating Provider services.

B. FOUR TYPES OF CLAIMS

As described below, there are four (4) categories of claims that can be made under the Plan, each with somewhat different claim and Appeal rules. There are different requirements based on the type of claim involved. The primary difference is the time frame within which claims and Appeals must be determined.

It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding what type of claim and/or what claims procedure to follow, contact the Health Plan’s Benefits Reimbursement Unit.

PRE-SERVICE CLAIM

A claim is a Pre-Service Claim if the Health Plan specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves Urgent Care, as defined below. Benefits under the Plan that require approval in advance are specifically noted in this Plan as being subject to Prior Authorization.
URGENT CARE CLAIM

An Urgent Care Claim is a special type of Pre-Service Claim. A claim involving Urgent Care is any Pre-Service Claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to Pre-Service Claims could seriously jeopardize the claimant's life, health or ability to regain maximum function or would—in the opinion of a Physician with knowledge of the claimant's medical Condition—subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

On receipt of a Pre-Service Claim, the Health Plan will make a determination of whether it involves Urgent Care, provided that, if a Physician with knowledge of the claimant's medical Condition determines that a claim involves Urgent Care, the claim shall be treated as an Urgent Care Claim.

POST-SERVICE CLAIM

A Post-Service Claim is any claim for a benefit under the Plan that is not a Pre-Service Claim, an Urgent Care Claim, or a Concurrent Care Claim.

CONCURRENT CARE CLAIMS

A concurrent care decision occurs where the Health Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two (2) types of Concurrent Care Claims: (1) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments, and (2) where an extension is requested beyond the initially approved period of time or number of treatments.

C. HOW TO FILE A CLAIM FOR BENEFITS

Except for Urgent Care Claims, discussed below, a claim for Plan benefits is made when a claimant (or authorized representative) submits a written Medical Reimbursement form to the Benefits Reimbursement Unit or a Prescription Drug Reimbursement form to the Pharmaceutical Services Department. An itemized receipt for the services or supplies rendered, along with a written proof of payment made, should be submitted with the form. The request for reimbursement should include the name of the Insured, the policy number, and the Insured’s signature.

Reimbursement forms are available from the Health Plan’s Customer Service Department. Forms are also available on the Health Plan’s website at www.myFHCA.org and through the Member Portal. A Reimbursement form will be treated as received by the Health Plan (a) on the date it is hand-delivered to the Health Plan or (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope addressed to the Benefits Reimbursement Unit or Pharmaceutical Services Department. The postmark on any such envelope will be proof of the date of mailing.

Claims for medical services must be sent to:

Florida Hospital Care Advantage
Reimbursement requests for Prescription Drugs must be sent to:

Florida Hospital Care Advantage
ATTN: Pharmaceutical Services Department
6450 US HWY 1
Rockledge, FL 32955

POST-SERVICE CLAIMS

A Post-Service Claim must be filed within six (6) months following receipt of the medical service, treatment or product to which the claim relates. With respect to Prescription Drug benefits, Cost-Sharing provisions, including Deductible, Copayments and Coinsurance, for Prescription Drug benefits are typically applied by the Pharmacy when a Prescription is filled, and no further action is required on the part of the Insured. However, if an Insured believes the Pharmacy has applied the wrong Cost-Sharing amounts, the Insured may pay the amount determined by the Pharmacy and submit a claim for reimbursement to the Health Plan, following the procedures for Post-Service Claims.

It is not expected that an Insured will make payment, other than their required Cost-Share, for any benefits provided hereunder. However, if such payments are made, the Insured shall submit a timely claim for reimbursement to the Health Plan. In order for a claim for reimbursement to be considered, the Insured must provide written proof of any payment made in a form acceptable by the Health Plan (Medical Reimbursement and Prescription Drug Reimbursement Forms). An itemized bill is required for all reimbursement requests. The Benefit Reimbursement Unit or Pharmaceutical Services Department reserves the right to request additional documentation in support of claim or reimbursement requests. Claims submitted after the six (6) month deadline will be denied.

URGENT CARE CLAIMS

In light of the expedited time frames for decision of Urgent Care Claims, an Urgent Care Claim for benefits may be submitted to the Benefits Reimbursement Unit or Pharmaceutical Services Department (see above for the mailing address). The claim should include at least the following information:

1. The identity of the claimant;
2. A specific medical Condition or symptom; and
3. A specific treatment, service, or product for which approval or payment is requested.

D. CLAIMS REVIEW AND DECISION

The Health Plan will pay, deny or request additional information for a claim within twenty (20) calendar days from the day it is received for electronic claims and within forty (40) calendar days from the day it is received for paper claims.
The Health Plan shall reimburse all claims or any portion of any claim, up to the Allowed Amount, within the time frames established by applicable federal regulations and regulatory guidelines of Florida State Statute. If a claim or a portion of a claim is contested by the Health Plan, the Insured or the Insured’s assignees shall be notified, in writing, that the claim is contested or denied. The notice (Explanation of Benefits) that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. Upon receipt of the additional information requested from the Insured or the Insured’s assignees, the Health Plan shall pay or deny the contested claim, or portion of the contested claim, within the established time frames and regulatory guidelines of Florida State Statute. The Health Plan shall pay or deny all claims according to the following time frames: no later than 120 days after receiving an electronic claim and no later than 140 days after receiving a paper claim.

Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. All overdue payments shall bear a simple interest rate as directed by the State of Florida.

Upon written notification by an Insured, the Health Plan shall investigate any claim of improper billing by a Physician, Hospital, or other Health Care Provider. The Health Plan shall determine if the Insured was properly billed for only those procedures and services that the Insured actually received. If the Health Plan determines that the Insured has been improperly billed, the Health Plan shall notify the Insured and the Provider of its findings and shall reduce the amount of payment to the Provider by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, the insurer shall pay to the Covered Person twenty (20) percent of the amount of the reduction, up to $500.

E. COORDINATION OF BENEFITS

Coordination of Benefits (COB) is a limitation of coverage and/or benefits to be provided by us. This provision is required by and subject to applicable federal and/or Florida law concerning coordination of health insurance benefits and will be modified to the extent necessary to enable us to comply with such laws.

COB determines the manner in which expenses will be paid when you are covered under more than one health plan, program, or policy providing benefits for Health Care Services. It is your responsibility to provide us and your Physician with information concerning any duplication of coverage under any other health plan, program, or policy you or your Covered Dependents may have. This means you must notify us in writing if you have other applicable coverage or if there is no other coverage. You may be requested to provide this information at the time you apply for this Group Plan, at enrollment by written correspondence annually thereafter, or in connection with a specific Health Care Service you receive. If we do not receive the information we request from you, we may deny your claims, and you will be responsible for payment of any expenses related to denied claims.

COB is designed to avoid the costly duplication of payment for Health Care Services and/or supplies under multiple health coverage plans. Because of this provision, the sum of the benefits that would be payable under all plans will not exceed 100% of the total allowed expenses actually incurred.

PLANS AFFECTED
If any of the other health coverage plan(s) an Insured has covers at least a portion of health care services or supplies covered under this Group Plan, coordination may take place. Not all health coverage plans will be considered in this coordination process. The plans that will be considered are the following:

1. Any group insurance, group-type self-insurance or HMO/POS plan, including coverage under labor-management, trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans;

2. Any service plan contracts, group practice, individual practice, or other prepayment coverage on a group basis;

3. An insurance agreement, including an automobile insurance agreement;

4. Any coverage under governmental programs, including Medicare, and any coverage required or provided by any statute.

Each policy, plan, or other arrangement for benefits or services that the Insured has will be considered separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other programs into consideration in determining its benefits and that portion which does not.

The amount of our payment, if any, when we coordinate benefits under this section, is based on whether or not we are the primary payer. When we are primary, we will pay for Covered Services without regard to coverage under other plans. When we are not primary, our payment for Covered Services may be reduced so that total benefits under all your plans will not exceed 100% of the total reasonable expenses actually incurred for Covered Services. **In the event that the primary payer’s payment exceeds our Allowed Amount, no payment will be made for such services.**

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed as a benefit paid.

**ORDER OF BENEFIT DETERMINATION**

If the health benefits of all of the health coverage plans the Insured is covered under would have exceeded the actual cost of the services or supplies rendered in the absence of this provision, this coordination process will reduce the payment by one or more of the plans to eliminate the excess payment. To determine the order in which companies will be considered and plan benefits reviewed to determine the appropriate benefit payments, the following guidelines will be used:

1. The benefits of the plan that covers the person on whose expense the claim is based as an employee shall be determined before the benefits of the plan that covers the person as a dependent.

2. In the case of a person for whom a claim is made as a dependent child (except for cases where the Covered Dependent’s parents are separated or divorced), the parents’ birth dates will be used to determine the order of benefit payments. The benefits of the parent’s plan whose date of birth, excluding year of birth, occurs earlier in the Calendar Year shall be determined before the benefits of the plan of the parent whose date of
birth, excluding year of birth, occurs later in the Calendar Year. (If either parents' plan
does not have a similar "birthday rule" provision, the criteria shall not be applied, and the
rule set forth in the plan which does not have the "birthday rule" provision shall
determine the order of benefits.)

3. In the case of a person for whom a claim is made as a dependent child whose parents are separated or divorced:

   a. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of the plan that cover the child as a dependent of the parent with custody of the child will be determined before the benefits of the plan which cover the child as a dependent of the parent without custody.

   b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a program which cover that child as a dependent of the parent with custody shall be determined before the benefits of a plan which cover that child as a dependent of the step-parent. The benefits of a plan which cover that child as a dependent of a step-parent will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

   c. If there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which cover the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other program which cover the child as a dependent child.

4. When rules 1, 2., or 3 do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period shall be determined before the plan which has covered such person the shorter period of time, provided that:

   a. The benefits of the plan covering the person as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other plan covering such person as an active employee; and

   b. If either program does not have a provision regarding laid-off or retired employees, which results in each program determining its benefits after the other, then the provisions of 4.a. above shall not apply.

When this coordination process reduces the total amount of benefits otherwise payable to a Covered Employee or Covered Dependent under this Group Plan, each benefit that would be payable in the absence of this provision will be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Group Plan.

**MEDICARE ELIGIBLES**

This section explains how the benefits under this Group Plan coordinate with benefits available under Medicare when you become covered under Medicare and continue to be eligible and covered under the Group Plan. Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health
Maintenance Organization (HMO) or comparable coverage that is an approved alternative to Parts A and B of Medicare.

If you are eligible and enrolled in Medicare due to age (age 65 or older), then:

1. This Group Plan will be the primary plan if your coverage under this Group Plan is based on your or your Spouse's current employment.
2. Medicare will be primary if you elect Medicare as the primary payer or if you are retired.

If you are eligible and enrolled in Medicare due to End stage renal disease (ESRD), then:

1. The Group Plan will be the primary plan for the first thirty (30) months, and
2. Medicare will be the primary payer after the first thirty (30) months.

If you are eligible and enrolled in Medicare due to a disability other than ESRD and your employer has more than 100 employees, the Group Plan will be the primary plan.

In order to properly administer this provision, the Large Employer shall provide the Health Plan the names of employees, age 65 or older:

1. Who are covered under this Group Plan;
2. Who are employed (not retired);
3. Who have not elected Medicare as primary payer of their health insurance claims; and
4. Who are not eligible for Medicare due to the ESRD coordination period.

The Large Employer shall provide the Health Plan the names of Spouses, age 65 or older, of current employees of any age:

1. Who are covered under this Group Plan;
2. Who have not elected Medicare as primary payer of their health insurance claims; and
3. Who are not eligible for Medicare due to the ESRD coordination period.

This Medicare Secondary Payer section shall be subject to modification if necessary to conform to or comply with Federal Statutory and Regulatory Medicare Secondary Payer provisions, as those provisions relate to Medicare beneficiaries who are covered under this Group Plan.

**F. THIRD PARTY LIABILITY AND RIGHT OF RECOVERY**

A Covered Employee or Covered Dependent may receive covered Health Care Services or other benefits or services in relation to an illness, a Sickness, or a bodily injury incurred by the Insured as a result of the act or omission of an Other Party for which an Other Party may be liable or legally responsible to pay expenses, compensation and/or damages.

An Other Party is defined to include any of the following:
1. The party or parties who caused the illness, Sickness or bodily Injury;

2. The insurer or other indemnifier of the party or parties who caused the illness, Sickness or bodily Injury;

3. A guarantor of the party or parties who caused the illness, Sickness or bodily Injury;

4. The Covered Employee’s or Covered Dependent’s own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage);

5. A Workers’ Compensation insurer; or

6. Any other person, entity, policy, or plan that is liable or legally responsible in relation to the illness, Sickness or bodily Injury.

When the Health Plan is obligated to and does pay for or arrange for covered Health Care Services that an Other Party is liable or legally responsible to pay for, the Health Plan may:

1. Subrogate, that is, take over the Insured’s right to receive payments from the Other Party. The Insured or his/her legal representative will transfer to the Health Plan any rights he/she may have to take legal action arising from the illness, Sickness or bodily Injury to recover any sums paid under the Group Plan on behalf of the Insured; and/or

2. Recover from the Insured or his/her legal representative any benefits paid under the Group Plan on the Insured’s behalf out of the recovery made from the Other Party (whether by lawsuit, settlement, or otherwise) whether paid directly or indirectly to you/the Insured, his spouse, dependents, beneficiaries or estate, whether held in trust or constructive trust for the benefit of you/the Insured, his spouse, dependents, beneficiaries or estate.

The Insured and his/her legal representative must cooperate fully with the Health Plan in regards to subrogation and recovery rights. The Insured and his/her legal representative will, upon request from the Health Plan, provide all information and sign and return all documents necessary to exercise the Health Plan’s rights under this provision. The Health Plan’s subrogation and recovery rights are not contingent upon the receipt of such documents. The Insured and his/her legal representative will do nothing to prejudice the Health Plan’s rights.

The Health Plan will have a first lien upon any recovery, whether by settlement, judgment, mediation, arbitration or otherwise, that the Insured (whether paid directly or indirectly to you/the Insured, his spouse, dependents, beneficiaries or estate, whether held in trust or constructive trust for the benefit of you/the Insured, his spouse, dependents, beneficiaries or estate) receives or is entitled to receive from an Other Party (whether or not such recovered funds are designated as payment for medical expenses). This lien will not exceed:

1. The amount of benefits paid by the Health Plan for the illness, Sickness or bodily Injury, plus the amount of all future benefits which may become payable under the Group Plan which result from the illness, Sickness or bodily Injury. The Health Plan will have the right to offset or recover such future benefits from the amount received from the Other Party;
2. If the benefits were covered by a capitation fee, the fee for service equivalent, determined on a just and equitable basis as provided by law; or

3. The amount recovered from the Other Party.

Upon recovery from the Other Party due to settlement, judgment, mediation, arbitration or otherwise, the Insured and his/her legal representative agree to hold in a separate trust, for the benefit of the Health Plan, an amount equal to Health Plan’s first lien on the total recovery. In addition, the Insured and his/her legal representative agree to hold the first lien amount in trust until such time as the Health Plan’s first lien has been satisfied by payment of the first lien amount to the Health Plan.

If the Insured or his/her legal representative makes any recovery from an Other Party and fails to reimburse the Health Plan for any benefits which arise from the illness, Sickness or bodily Injury, then:

1. The Insured and his/her legal representative will be liable to the Health Plan for the amount of the benefits paid under the Group Plan;

2. The Insured and his/her legal representative will be liable to the Health Plan for the costs and attorneys’ fees incurred by the Health Plan in collecting those amounts;

3. The Health Plan may reduce future benefits payable under the Group Plan for any illness, Sickness or bodily Injury, up to the amount of the payment that the Insured or his/her legal representative has received from the Other Party; and

4. The Health Plan may terminate the Insured’s coverage under this Group Plan.

The Health Plan’s recovery rights and first lien rights will not be reduced due to the Insured’s own negligence or due to the attorney’s fees and costs. The Health Plan’s recovery rights and first lien rights will not be reduced due to the Insured not being made whole. The “make whole” doctrine or rule does not apply and is specifically excluded under this Group Plan.

For clarification, this provision for third-party liability, subrogation and right of recovery applies to the Insured, which is defined under the Health Plan to include Eligible Dependents, and to any recovery from the Other Party by or on behalf of the estate of the Insured.

G. RIGHT TO RECEIVE AND RELEASE INFORMATION

The Health Plan has the right to receive and release necessary information to administer this Group Plan. By accepting coverage under this Health Plan, the Covered Employee or Covered Dependent gives permission for the Health Plan to obtain from or release to any insurance company, other organization or person any information necessary to determine whether this provision or any similar provision in other plans applies to a claim and to implement such provisions. Any person who claims benefits under this Group Plan agrees to provide to the Health Plan information that may be necessary to implement this provision.

H. RIGHT OF RECOVERY
If the Health Plan makes larger payments than are required under this Group Plan, then the Health Plan has the right to recover any excess benefit payment from any person to whom such payments were made.

I. NON-DUPLICATION OF GOVERNMENT PROGRAMS

The benefits of this Group Plan shall not duplicate any benefits that are received by or paid to the Covered Employee or Covered Dependent under governmental programs, such as Medicare, Veterans Administration, TRI-CARE (CHAMPUS), or any Workers' Compensation Act, to the extent allowed by law. In any event, if this Group Plan has duplicated such benefits, all sums paid or payable under such programs shall be paid or payable to the Health Plan to the extent of such duplication.

Charges for expenses in connection with any condition for which a Covered Employee or Covered Dependent has received, whether by settlement or by adjudication, any benefit under Workers’ Compensation or Occupational Disease Law or similar law are not covered by the Health Plan. If the Covered Employee or Covered Dependent enters into a settlement giving up rights to recover past or future medical benefits under Workers’ Compensation law, this Group Plan will not cover past or future medical services that are the subject of or related to that settlement. In addition, if the Covered Employee or Covered Dependent is covered by a Workers’ Compensation program that limits benefits, if other than specified Health Care Providers are used and the Covered Employee or Covered Dependent receives care or services from a Health Care Provider not specified by the program, the Group Plan will not cover the balance of any costs remaining after the program has paid.

J. ADVERSE DETERMINATIONS

A decision on a claim is “adverse” if it is: (a) a denial, reduction, or termination of or (b) a failure to provide or make payment (in whole or in part) for a Plan benefit. If a claim is denied for any reason, the Insured will receive a notice explaining the reason for the denial and the process for filing an Appeal as further provided in this Certificate. An Insured has a right to Appeal an Adverse Determination under these claims and Appeal procedures.

Within sixty (60) days after your claim is received, you will receive a written notice (Explanation of Benefits) of the decision. If your claim is denied, in whole or in part, the Benefit Reimbursement Unit will further notify you of your right to additional review of your denied claim.

If your request for review is denied, in whole or in part, and you still disagree with the decision, within sixty (60) days of the date you receive written notice, you must deliver to the Benefits Reimbursement Unit a written request for a final claims determination at the address provided in the How to File a Claim for Benefits section above. Your request for a final claims determination should include any documentation supporting your claim.

ELIGIBILITY, ENROLLMENT, AND RESCISSION OF COVERAGE

All claims or disputes regarding eligibility and enrollment, including disputes relating to a dependent’s eligibility and/or dependents removed from coverage due to failure to provide documentation substantiating their eligibility, must be submitted in writing to the Benefits Reimbursement Unit (see the How to File a Claim for Benefits section above for the mailing address).
For claim disputes relating to dependents removed from coverage due to failure to provide documentation substantiating their eligibility, you should include the documentation that will prove the dependent is eligible along with your letter. If approved, coverage will be reinstated retroactively sixty (60) days from the date you submit your Appeal or the date your dependent was removed from coverage. In this event, if your coverage level changed, contributions for coverage will be collected from the date coverage was reinstated. You will be responsible for any claims incurred between the time coverage ended and the date it was reinstated.

K. RIGHT TO REQUIRE MEDICAL EXAMS

The Health Plan has the right to require medical exams be performed on any claimant for whom a claim is pending as often as the Health Plan may reasonably require. If the Health Plan requires a medical exam, it will be performed at the Health Plan’s expense. The Health Plan also has the right to request an autopsy in the case of death, if state law so permits.

L. LEGAL ACTIONS AND LIMITATIONS

No action at law or in equity may be brought to recover under this Group Plan until at least sixty (60) days after a written claim and supporting documentation has been filed with the Health Plan. If action is taken after the sixty (60) day period, it must be taken prior to the expiration of the deadlines explained in the Right to Legal Action section of this Certificate.

M. UNUSUAL CIRCUMSTANCES

If the rendering of services or benefits payable under this Group Plan is delayed or impractical due to: (a) complete or partial destruction of Network facilities; (b) war; (c) riot; (d) civil insurrection; (e) major disaster; (f) disability of a significant part of participating Hospitals and practitioner Network; (g) epidemic; (h) a labor dispute not involving the Health Plan, participating Hospitals and other Participating Providers, Participating Providers will use their best efforts to provide services and benefits within the limitations of available facilities and personnel. However, neither the Health Plan, nor any Participating Providers, shall have any liability or obligation because of a delay or failure to provide such services or benefits. If the rendering of services or benefits under this Group Plan is delayed due to a labor dispute involving the Health Plan or Participating Providers, non-Emergency Care may be deferred until after the resolution of the labor dispute.

N. PROOF OF LOSS

Written proof of loss must be given to the Health Plan within ninety (90) days after the end of each period for which the insurer is liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, the Health Plan shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified unless the claimant was legally incapacitated.

VIII. COMPLAINT, GRIEVANCE AND APPEAL PROCEDURES

A Complaint is an informal expression of dissatisfaction related to benefits or services provided under this Plan. A Grievance is a formal Complaint regarding service issues or the quality of care provided. An Appeal is a formal dispute regarding an Adverse Coverage Determination (denial of coverage or application of Cost-Share). The Health Plan administers an informal
Complaint procedure, a formal Grievance procedure, and a formal Appeal procedure. All procedures take medical urgency into account.

A. THE INFORMAL COMPLAINT PROCEDURE

Many Complaints can be resolved by using the informal Complaint procedure, which consists of personal and informal discussion about the problem. You or your authorized representative should contact Customer Service at (844) 522-5279 with any initial Complaint, and the Customer Service Representative will make every effort to resolve the problem within three (3) working days. A formal Grievance may also be filed according to the procedure defined below, with assistance provided if necessary.

B. GRIEVANCE PROCEDURES

Formal Grievances must be submitted in writing within one (1) year of the event causing the Grievance. To file a written Grievance, your or your authorized representative must submit a Grievance containing the following information:

1. Your name, address and identification number;
2. A summary of the concern, along with any supporting documentation/medical records;
3. A description of relief sought;
4. Your or your authorized representative’s signature;
5. The date the Grievance is signed.

Formal Grievances must be sent to:

Florida Hospital Care Advantage  Fax:  (844) 522-5279
ATTN:  Grievance Coordinator Email:  FHCA@Health-First.org
6450 U.S. Highway 1
Rockledge, FL 32955

Depending on the nature of the Grievance, Appeal rights may be available and will be communicated with the decision.

C. APPEAL PROCEDURES – GENERAL INFORMATION

If benefits are denied in whole or in part, the Health Plan will provide your or your authorized representative written notice of the denial. The denial notice will include:

1. The reason for the denial;
2. A reference to the benefit provision, guideline or other criterion on which the decision was based, and notification that the actual provision, guideline or criteria is available upon request;
3. A description of Appeal rights, including the right to submit written comments, documents or other information relevant to the Appeal;
4. An explanation of the Appeal process, including the right to representation and time frames for deciding Appeals;

5. Information on the Expedited Appeal process.

For urgent medical situations, an Expedited Appeal procedure is available if applying the standard time frame would jeopardize your health or ability to regain maximum functioning. The Health Plan reserves the right to determine if your situation warrants the expedited process and will not expedite Appeals for services that have already been received.

Appeal reviews will take into account all new information, regardless of whether the information was considered in the initial decision on the claim.

Your or your authorized representative shall have the right to access, upon request and without charge, copies of all documents, records and other information relevant to your Appeal.

D. APPEAL PROCEDURE – FIRST LEVEL OF REVIEW

SUBMITTING APPEALS

Appeals must be submitted within one (1) year of being notified of an Adverse Coverage Determination. To initiate the standard Appeal procedure, you or your authorized representative should submit a written Appeal containing the information listed below. Expedited Appeals may be submitted verbally.

1. Your name, address and identification number;
2. A summary of the concern, along with any supporting documentation/medical records;
3. A description of relief sought;
4. Your or your authorized representative’s signature;
5. The date the Appeal is signed.

Written Appeals must be sent to:

Florida Hospital Care Advantage  Fax:  (844) 522-5279
ATTN: Appeal Coordinator  Email: FHCA@Health-First.org
6450 U.S. Highway 1
Rockledge, FL 32955

Expedited Appeals may be filed verbally by contacting an Appeal Coordinator at (844) 522-5279 (toll-free) any time.

FIRST LEVEL REVIEW TIME FRAMES

For standard pre-service Appeals, a decision will be made and written notification will be provided within fifteen (15) calendar days of receipt of the Appeal.
For standard post-service Appeals, a decision will be made and written notification will be provided within thirty (30) calendar days of receipt of the Appeal.

For Expedited Appeals, a decision will be made as quickly as your medical Condition requires, but in no longer than seventy-two (72) hours. Verbal notice of the decision will be provided within the 72-hour time frame, with a written decision provided within three (3) days after the verbal notification.

Extensions: One fourteen (14) calendar day extension is permitted if additional information is necessary to make a decision on the Appeal, and you or your authorized representative agrees to the extension. In such case, information will be requested within the resolution time frames listed above, and forty-five (45) days will be allowed in which the information must be provided. A decision will be made within fifteen (15) days after the information is received, or if the information is not received, when this period has elapsed.

AUTHORIZED REVIEWERS

Appeals related to non-medical issues will be reviewed by an appropriate person with problem-solving authority for a final decision. An individual who has made a previous decision on the case will not be involved with the decision upon review, nor will their subordinates.

If the Appeal involves an Adverse Determination based on Medical Necessity, a Physician with appropriate medical expertise will review the case and make a determination. A Physician who has made a previous decision on the case will not be involved with the decision upon review, nor will their subordinates.

E. APPEAL PROCEDURE – SECOND-LEVEL REVIEW (MEMBER ASSISTANCE PANEL HEARING)

REQUESTING A SECOND-LEVEL APPEAL REVIEW

If a first-level Appeal is not resolved in your favor, you or your authorized representative may request a second-level Appeal hearing by the Health Plan’s Member Assistance Panel. The request may be made verbally or in writing within 180 days of receipt of the first-level decision. Requests must be made through an Appeal Coordinator at the address or phone number listed under the first-level appeal procedure. The request for second-level review should include any additional information you would like considered, including medical records, letters from Providers, or any other helpful information.

The Member Assistance Panel Hearing will be scheduled at the administrative offices of the Health Plan, or a location reasonably convenient to you or your authorized representative. The majority of the Member Assistance Panel representatives shall be individuals who previously were not involved in any prior decision on the case and will consist of Health Plan management or clinical professionals qualified to review the issue under Appeal, with external individuals included as appropriate. You or your authorized representative may attend the Member Assistance Panel in person, by teleconference or through any other available technology and will have sufficient time to present your case and provide any additional information you would like considered.

An expedited second-level Appeal process is available if the standard time frame would seriously jeopardize your health or ability to regain maximum functioning, or would subject you
to severe pain that cannot be adequately managed without the requested care in the opinion of your Physician. We will decide if the expedited process is needed and will make a decision within seventy-two (72) hours if the fast process is granted. If your Appeal qualifies for the expedited process, you may also request external review. To request an Expedited Appeal or external review, call Customer Service toll-free at (844) 522-5279.

SECOND-LEVEL REVIEW TIME FRAMES

For standard pre-service Appeals, the Member Assistance Panel Hearing will generally be scheduled within ten (10) calendar days of the request for the second-level review, or when a delay is requested by you or your authorized representative, within thirty (30) days of the second-level appeal request. A decision will be made and written notification will be provided within five (5) calendar days after the hearing.

For standard post-service Appeals, the Member Assistance Panel Hearing will be scheduled within twenty-five (25) calendar days of the request for the second-level review. A decision will be made and written notification will be provided within five (5) calendar days after the hearing.

For Expedited Appeals, the Member Assistance Panel Hearing will be scheduled in a time frame that will allow a decision to be made within seventy-two (72) hours of receipt of the initial Appeal, or when a delay is requested by you or your authorized representative, within thirty (30) days of the second-level Appeal request. A decision will be made and verbal notification will be provided to the Insured or their authorized representative within seventy-two (72) hours of the initial Appeal request, with written notification provided within three (3) calendar days after the verbal notification. If a delay is requested, a written decision will be provided within five (5) calendar days after the hearing.

Extensions: One fourteen (14) calendar day extension is permitted if additional information is necessary to make a decision on the Appeal, and you or your authorized representative agrees to the extension. If the Appeal cannot be resolved within the required time frame, you will be notified of the need for an extension in writing before the required time frame has elapsed. This written notice will include the reason for the delay, request your agreement to the extension, and will inform you of the date by which the decision will be made. For Expedited Appeal extensions, you may be notified verbally within the 72-hour time frame, with a written notice provided within three (3) calendar days.

F. EXTERNAL REVIEW

External review is available for Appeals that involve Medical Necessity or the determination of whether a service is experimental or investigational. Within four (4) months after receiving a final determination from the Health Plan regarding an adverse outcome of a second-level Appeal, you or your authorized representative has the right to request external binding review. There is no dollar limit on issues eligible for review, nor any cost associated with this review.

If your medical Condition warrants an Expedited Appeal process (as determined by the Health Plan), expedited external review may be requested when an Expedited Appeal is requested through the Health Plan (at any level of Appeal) and after the internal Appeal process has been completed.

To request external review, you or your authorized representative must contact the Health Plan by writing to the address or calling the number below:
For standard external review requests, the Health Plan will complete a preliminary review of the request to determine if the Appeal is eligible for external review within five (5) business days of receipt of the request. For Expedited Appeals (as determined by the Health Plan), this preliminary review will be conducted the same day the request is received.

ELIGIBILITY REQUIREMENTS FOR EXTERNAL REVIEW

An Adverse Coverage Determination is eligible for external review under the following circumstances:

1. The request for external review is filed by you or your authorized representative;

2. The request is made in the required time frame, as indicated above;

3. The request is made by the correct method (standard requests in writing);

4. You must be (or must have been) covered under the plan when the item or service was requested (for pre-service Appeals) or when it was received (for post-service Appeals);

5. The Adverse Coverage Determination does not relate to your failure to meet the requirements for eligibility under the terms of this Group Plan; and

6. One of the following has occurred:
   a. The entire internal Appeal process has been completed;
   b. The Health Plan deems the internal Appeal process completed; or
   c. An Appeal meeting expedited criteria has been filed with the Health Plan.

Within one (1) business day after completing the preliminary review, the Health Plan will notify you or your authorized representative in writing of the Appeal's eligibility for external review. If the Appeal is not eligible, the reason(s) for ineligibility will be provided, with contact information for the Employee Benefits Security Administration (866-444-3272). If the request is incomplete, the notification will describe the information needed to complete the request, allowing for submission of the information within the original four-month filing period, or within forty-eight (48) hours after receipt of the notification, whichever is greater.

For Appeals eligible for external review, the Health Plan will assign the case to an Independent Review Organization (IRO) accredited by a nationally-recognized accrediting organization to conduct external review, ensuring against bias by rotating cases between at least three (3) IROs. The IRO will notify you or your authorized representative in writing of the Appeal's acceptance for external review and of your right to submit additional information within ten (10) calendar days of receiving the request. The final decision will be issued within forty-five (45) days after receiving the request. For Expedited Appeals, the IRO will notify you or your
authorized representative of the decision as quickly as your medical Condition requires, but in no later than seventy-two (72) hours after receiving the request. If the notification is made verbally, written notice will be provided within forty-eight (48) hours after the verbal notice.

G. ADDITIONAL ASSISTANCE WITH GRIEVANCES & APPEALS

You or your authorized representative has the right to contact, at any point throughout this process, Florida’s Agency for Healthcare Administration or Department of Financial Services.

Florida’s Agency for Healthcare Administration

**Agency for Health Care Administration**
Bureau of Managed Health Care
Building 1, Room 339, MS 26
2727 Mahan Drive
Tallahassee, Florida 32308
850-921-5458 or 888-419-3456 (toll-free)

Florida’s Department of Financial Services:

**Department of Financial Services**
Division of Consumer Services, 5th Floor
200 East Gaines Street
Tallahassee, Florida 32399-0322
Toll-free: (877) 693-5236
Email: Consumer.Services@myfloridacfo.com

H. RIGHT TO LEGAL ACTION

If this Group Plan is subject to ERISA regulations, civil action may be taken under ERISA §502(a) after completing the internal Appeal process. The deadline to file legal action is as follows:

1. Six (6) months after completion of the internal Appeal procedure, or

2. Sixty (60) months after the earlier of:
   a. The date benefits were denied,
   b. The date benefits were received at a level less than what you believed was provided under this Group Plan, or
   c. The date you knew, or reasonably should have known, the principal facts upon which the claim was based.

IX. THE HEALTH PLAN’S PHARMACY PROGRAM

The benefits and provisions described within this section are applicable only to Group Plans that include a Prescription Drug Rider. When applicable, it is important that you review the information herein, along with the information set forth in the Prescription Drug Rider attached to this Certificate, to ensure you understand your coverage through the Health Plan’s
Pharmacy Program.

Coverage for Prescription Drugs and supplies is provided through the Health Plan’s Pharmacy Program described in this section. We provide coverage to you for certain Prescription Drugs and supplies. Please note that before payment will be made for covered Prescription Drugs and supplies, the Calendar Year Deductible, if applicable, must be satisfied. The Prescription Drug Rider attached to this Certificate will indicate whether or not Prescription Drugs and supplies are subject to a Calendar Year Deductible, and if so, whether or not the Calendar Year Deductible is integrated with your medical coverage.

Once the Calendar Year Deductible, if applicable, has been satisfied, you must pay, at the time of purchase, the appropriate Copayment or Coinsurance percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance, as applicable, indicated on the Prescription Drug Rider for each Prescription.

Covered Prescription Drugs are categorized into tiers and listed in your Group Plan Formulary. In the Formulary, you will find Preferred Generic Prescription Drugs, Non-Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Brand Name Prescription Drugs, and Specialty Drugs that are covered under your Group Plan. Your Group Plan may not cover all tiers listed on the Formulary. Please see the Prescription Drug Rider attached to this Certificate.

The Formulary is subject to change. Updated Formularies are posted to the Health Plan’s website at www.myFHCA.org and the member portal as changes are made. You may also contact the Customer Service Department for assistance.

You may be able to reduce your out-of-pocket expenses by: 1) using Participating Pharmacies, 2) choosing Preferred Prescription Drugs rather than Non-Preferred Prescription Drugs, and 3) asking your Physician to write for the high-strength tablet and allow you to split the tablet in half. Please see “Pill Splitting Program” in the Pharmacy Utilization Review Programs section below for more information.

To verify if a Pharmacy is a Participating Pharmacy, you may access the Provider/Pharmacy Directory on our website at www.myFHCA.org, or you can call the Customer Service Department for assistance.

A. COVERED PRESCRIPTION DRUGS AND SUPPLIES

A Prescription Drug is covered only if it is:

1. Prescribed by a Physician or other Health Care Provider acting within the scope of his or her license;

2. Dispensed by a Pharmacist;

3. Medically Necessary;

4. Authorized for coverage by us, if prior coverage authorization is required by us as indicated with a unique identifier on the Formulary;

5. Not specifically or generally limited or excluded herein; and
6. Approved by the U.S. Food and Drug Administration (FDA) and assigned a National Drug Code (NDC).

In the case of a Specialty Drug (Prescription Drugs that are identified as Specialty Drugs in the Formulary), a Prior Authorization may be required. Specialty Drugs must be obtained at a specialty Pharmacy designated by the Health Plan’s Pharmacy Department. See your Formulary for more information.

A supply is covered **only** if it is:

1. A Covered Prescription supply;
2. Prescribed by a Physician or other Health Care Provider acting within the scope of his or her license;
3. Authorized for coverage by us, if prior coverage authorization is required by us.
4. Medically Necessary, and
5. Not specifically or generally limited or excluded herein.

**B. COVERAGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES**

In providing benefits under the Health Plan’s Pharmacy Program, we may apply the benefit guidelines set forth below, as well as any other applicable payment rules specific to particular Covered Services listed in this Certificate.

**CONTRACEPTIVE COVERAGE**

Oral, transdermal, intravaginal, and intramuscular contraceptives are covered. Due to the Preventive Care provision of the Affordable Care Act, some of these contraceptives will be at no Cost-Share. Refer to the current Formulary for an updated list. We reserve the right to add, remove or reclassify any Prescription Drug in the Formulary at any time.

**DIABETIC COVERAGE**

All covered Prescription Drugs and supplies used in the treatment of diabetes are covered, subject to the limitations and exclusions listed in this Certificate. Insulin is **only** covered if prescribed by a Physician or other health care professional acting within the scope of his or her license. Syringes and needles for injecting insulin are covered when prescribed in conjunction with insulin. The following supplies and equipment used in the treatment of diabetes are covered under this Health Plan’s Pharmacy Program: blood glucose testing strips, lancets, blood glucose meters, and syringes and needles. Please see the Formulary for approved products. Non-Formulary supplies require Prior Authorization.

**Exclusion:** All supplies used in the treatment of diabetes, except those that are covered Prescription supplies, are excluded from coverage under this program.

**MINERAL SUPPLEMENTS AND VITAMINS COVERAGE**
All Mineral Supplements and Vitamins are excluded from coverage, except for prenatal vitamins and certain preventive medications that are noted on the Formulary with a NCS (No Cost-Share) designee.

C. THE HEALTH PLAN’S PHARMACY PROGRAM LIMITATIONS AND EXCLUSIONS

Coverage and benefits for covered Prescription Drugs and supplies are subject to the following limitations, in addition to all other provisions and exclusions in this Certificate:

1. We will not cover more than the maximum supply, as set forth in the Formulary, per Prescription for covered Prescription Drugs and supplies.

2. Prescription refills beyond the time limit specified by state and/or federal law are not covered.

3. Certain covered Prescription Drugs and supplies require prior coverage authorization in order to be covered.

4. Prescription Drugs not on the current Formulary are not covered.

5. Drugs that do not, by Federal or state law, require a Prescription (i.e., Over-the-Counter Drugs) are not covered, except certain preventive medications that are noted on the Formulary with a NCS (no Cost-Share) designee.

6. Any legend drug for which an Over-the-Counter equivalent is available without a Prescription (i.e., Lotrimin) is excluded from coverage.

7. Any Drug labeled "Caution: limited by federal law to investigational use" or experimental Drugs are not covered.

8. We will not cover the replacement of lost, damaged, or stolen Prescriptions.

9. All new drugs approved by the FDA will be excluded from the preferred drug list/Formulary, unless the Health Plan’s Pharmacy and Therapeutics Committee, in its sole discretion, decides to waive this exclusion with respect to a particular Drug.

Expenses for the following are excluded:

1. Any Drug or supply which can be purchased over-the-counter.

2. All supplies other than covered Prescription supplies.

3. Any Drugs or supplies dispensed prior to the Effective Date or after the termination date of coverage for this Group Plan.

4. Therapeutic devices, appliances, medical or other supplies and equipment (e.g., air and water purifiers, support garments, creams, gels, oils, and waxes), regardless of the intended use (except for covered Prescription supplies).

5. Prescription Drugs and supplies that are:
a. In excess of the limitations specified in this section, in the Formulary or on the
   Schedule of Benefits;
b. Furnished to you without cost;
c. Experimental or Investigational;
d. Compounded;
e. Indicated or used for the treatment of infertility;
f. Cosmetics or any drugs used for cosmetic purposes (such as Retin-A, Rogaine,
   Topical Minoxidil, Vaniqa, etc.);
g. Over-the-counter drugs for influenza;
h. Listed in the Homeopathic Pharmacopoeia;
i. Not Medically Necessary;
j. Indicated or used for sexual dysfunction (including Cialis, Levitra, Viagra, and
   Caverject). The exception described in exclusion number 9 does not apply to sexual
   dysfunction Drugs excluded under this paragraph;
k. Purchased from any source (including a Pharmacy) outside of the United States;
l. Prescribed by any health care professional not licensed in any state or territory (e.g.,
   Puerto Rico, U.S. Virgin Islands or Guam) of the United States of America.

6. Mineral supplements, fluoride or vitamins, except for prenatal vitamins and certain
   preventive medications that are noted on the Formulary with a NCS (No Cost-Share)
   designee.

7. Biological sera, blood and blood plasma products.

8. Drugs prescribed for uses other than the (FDA) approved label indications. This
   exclusion does not apply to any Drug that has been proven safe, effective and accepted
   for the treatment of the specific medical Condition for which the Drug has been
   prescribed, as evidenced by the results of good quality controlled clinical studies
   published in at least two or more peer-reviewed full length articles in respected national
   professional medical journals. This exclusion also does not apply to any Drug prescribed
   for the treatment of cancer that has been approved by the FDA for at least one
   indication, provided the Drug is recognized for treatment of your particular cancer in a
   Standard Reference Compendium or recommended for treatment of your particular
   cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not
   been approved for any indication are excluded.

9. Drugs that have not been approved by the FDA as required by federal law for distribution
   or delivery into interstate commerce.

10. Drugs that do not have a valid National Drug Code (NDC).

11. Any Drug prescribed in excess of the manufacturer’s recommended specifications for
    dosages, frequency of use, or duration of administration as set forth in the
    manufacturer’s insert for such Drug. This exclusion does not apply if we, in our sole
    discretion, waive this exclusion with respect to a particular Drug or therapeutic classes of
    Drugs.

12. Any benefit penalty reductions or any charges in excess of the Participating Pharmacy
    Allowance or Non-Participating Pharmacy Allowance.
13. Self-prescribed Drugs or supplies and Drugs or supplies prescribed by any person related to you by blood or marriage.

14. Food or medical food products, whether prescribed or not.

15. Prescription Drugs designated in the Formulary as not covered based on the following criteria:

   a. The Drug is no longer marketed;
   b. The Drug has been shown to have excessive adverse effects and/or safe alternatives;
   c. The Drug is available over-the-counter;
   d. The Drug has a preferred Formulary alternative;
   e. The Drug has a widely available/distributed AB rated generic equivalent formulation;
   f. The Drug has shown limited effectiveness in relation to alternative Drugs on the Formulary; or
   g. The number of insured affected by the change.

Please refer to the Formulary to determine if a particular Prescription Drug is excluded under this Group Plan.

D. PAYMENT RULES

Under this Health Plan’s Pharmacy Program, the amount you must pay for covered Prescription Drugs and supplies may vary depending on:

1. The participation status of the Pharmacy where purchased (i.e., Participating Pharmacy versus Non-Participating Pharmacy);

2. The terms of our agreement with the Pharmacy selected;

3. Whether you have satisfied the applicable Calendar Year Deductible, if applicable, and/or any amount you are required to pay as set forth in the Schedule of Benefits;

4. Whether the Prescription Drug is a Generic Prescription Drug or a Brand Name Prescription Drug;

5. Whether the Prescription Drug is in the Preferred Formulary tier; and

6. Whether the Prescription Drug is purchased from the Mail Order Pharmacy.

We reserve the right to add, remove or reclassify any Prescription Drug in the Formulary at any time.

Non-Formulary Prescription Drugs that are approved through the prior authorization process may be subject to the highest tier Cost-Share in the Group Plan Formulary. If the Prescription Drug Rider attached to this Certificate does not provide coverage for the highest Cost-Sharing tier, the medication is subject to the full contracted price, and this amount will not accumulate to the Out-of-Pocket Maximum Expense Limit.
E. PHARMACY ALTERNATIVES

For purposes of this section, there are two types of Pharmacies: Participating Pharmacies and Non-Participating Pharmacies.

PARTICIPATING PHARMACIES

Participating Pharmacies are Pharmacies participating in our Health Plan’s Pharmacy Network at the time you purchase covered Prescription Drugs and supplies. Participating Pharmacies have agreed not to charge or collect from you for each covered Prescription Drug and covered Prescription supply more than the amount set forth in the Prescription Drug Rider attached to this Certificate. With the Health Plan’s Pharmacy Program, there are two (2) types of Participating Pharmacies:

1. Pharmacies within our Network that have signed a Health Plan’s Participating Pharmacy Provider Agreement with us; and

2. The Mail Order Pharmacy.

To verify if a Pharmacy is a Participating Pharmacy, you may access the Provider/Pharmacy Directory on our website at www.myFHCA.org, or call our Customer Service Department whose phone number is located in your Certificate and on your ID card.

Prior to purchase, you must present your Health Plan ID card to the Participating Pharmacy. The Participating Pharmacy must be able to verify that we, in fact, cover you.

Charges for covered Prescription Drugs and supplies by a Participating Pharmacy will depend on the agreement then in effect between the Pharmacy and us.

MAIL ORDER PHARMACY

For additional details on how to obtain covered Prescription Drugs and supplies from the Mail Order Pharmacy, please refer to Provider/Pharmacy Directory, or go to www.myFHCA.org for specifics.

NON-PARTICIPATING PHARMACIES

A Non-Participating Pharmacy is a Pharmacy that has not agreed to participate in our Health Plan Pharmacy Network. Non-Participating Pharmacies have not agreed to accept our Participating Pharmacy Allowance as payment in full, less any applicable Cost-Share amounts due from you. You may be responsible for paying the full cost of the covered Prescription Drugs and supplies at the time of purchase and must submit a claim to us for reimbursement. Our reimbursement for covered Prescription Drugs and supplies will be based on the Non-Participating Pharmacy Allowance, less the applicable Calendar Year Deductible (if applicable) and the Copayment or Coinsurance percentage of the Non-Participating Pharmacy Allowance.

In order to obtain reimbursement for covered Prescription Drugs and supplies purchased at a Non-Participating Pharmacy, you must obtain an itemized paid receipt and submit it with a properly completed Prescription Drug Reimbursement form (with any required documentation) to:
Florida Hospital Care Advantage  
Attn: Pharmaceutical Services Department  
6450 US HWY 1  
Rockledge, FL 32955

F. PHARMACY UTILIZATION REVIEW PROGRAMS

Our pharmacy utilization review programs are intended to encourage the responsible use of Prescription Drugs and supplies.

We may, at our sole discretion, require that Prescriptions for select Prescription Drugs and supplies be reviewed under our pharmacy utilization review programs, then in effect, in order for there to be coverage for them. Under these programs there may be limitations or conditions on coverage for select Prescription Drugs and supplies, depending on the quantity, frequency or type of Prescription Drug.

Note: If coverage is not available or is limited, this does not mean that you cannot obtain the Prescription Drug or supply from the Pharmacy. It only means that we will not cover or pay for the Prescription Drug or supply. You are always free to purchase the Prescription Drug or supply at your sole expense.

Our pharmacy utilization review programs include the following:

STEP-THERAPY

Under this program, we may exclude from coverage certain Prescription Drugs unless you have first tried designated Drug(s) identified in the Formulary in the order indicated. In order for there to be coverage for such Prescription Drugs prescribed by your Physician, we must receive written documentation from you and your Physician that the designated Drugs in the Formulary are not appropriate for you because of a documented allergy, ineffectiveness or side effects.

Prior to filling your Prescription, your Physician may, but is not required to, contact us to request coverage for a Prescription Drug subject to the Step-Therapy program by following the procedures for prior coverage authorization outlined in the Formulary.

DOSE OPTIMIZATION (QUANTITY LIMITS) PROGRAM

Under this program, any Prescription Drug prescribed in excess of the maximum limitation noted in the Formulary is not covered, unless authorized in advance by the Health Plan.

PILL SPLITTING PROGRAM

For some medications, pills may be available in different strengths but still have the same price. You may be able to split these pills in half. Begin by asking your doctor if pill-splitting is right for you. If so, ask your doctor to write your prescription for half the number of pills and double the strength you normally need. For example, instead of 30 pills of 20 mg, you’d get a prescription for 15 pills of 40 mg. Then you (or the Pharmacy) can split them in half for the correct dose. This way, you save 50 percent of the cost.

PRIOR AUTHORIZATION PROGRAM
You are required to obtain Prior Authorization from us in order for certain Prescription Drugs and supplies to be covered. **Failure to obtain authorization will result in denial of coverage.** Prescription Drugs and supplies requiring Prior Authorization are designated in the Formulary.

For additional details on how to obtain prior coverage authorization, refer to the Formulary. Information on our pharmacy utilization review programs is published in the Formulary at [www.myFHCA.org](http://www.myFHCA.org), or you may call the Customer Service Department. Your Pharmacist may also advise you if a Prescription Drug requires Prior Authorization.

**G. ULTIMATE RESPONSIBILITY FOR MEDICAL DECISIONS**

The pharmacy utilization review programs have been established solely to determine whether coverage or benefits for Prescription Drugs and supplies will be provided under the applicable terms of the Certificate and attached Prescription Drug Rider. Ultimately, the final decision concerning whether a Prescription Drug should be prescribed must be made by you and the prescribing Physician. Decisions made by us in authorizing coverage are made only to determine whether coverage or benefits are available under the Group Plan and not for the purpose of providing or recommending care or treatment. We reserve the right to modify or terminate these programs at any time.

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for a Prescription Drug or supply, must be made solely by you and your treating Physician in accordance with the patient/Physician relationship. It is possible that you or your treating Physician may conclude that a particular Prescription Drug or supply is needed, appropriate, or desirable, even though such Prescription Drug or supply may not be authorized for coverage by us. In such cases, it is your right and responsibility to decide whether the Prescription Drug or supply should be purchased even if we have indicated that coverage and payment will not be made for such Prescription Drug or supply.

**X. DEFINITIONS**

This section defines many of the terms used in this Certificate. Defined terms are capitalized and have the meanings set forth in this section. Additionally, certain important terms and phrases not appearing in this section, which describe aspects of this Plan, may be capitalized.

**ACCIDENT** means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic Injury. This term does not include injuries caused by surgery or treatment for disease or illness.

**ACCIDENTAL DENTAL INJURY** means an Injury to Sound Natural Teeth (not previously comprised by decay) caused by a sudden, unintentional and unexpected event or force. The term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery or treatment for a disease or illness.

**ADOPTION OR ADOPT(ED)** means the process and act of creating a legal parent/child relationship declaring that the child is legally the child of the adoptive parents and their heir-at-law and entitled to all the rights and privileges and subject to all the obligations of a child born to such adoptive parents, or as otherwise defined by Florida law or similar applicable laws of another state.
ADVERSE DETERMINATION means a coverage determination by the Health Plan that an admission, availability or care, continued stay, or other medical services have been reviewed and, based upon the information provided, does not meet the Health Plan’s requirements for Medical Necessity, appropriateness, health care setting, or level of care for effectiveness. Coverage for the requested service is therefore denied, excluded, reduced or terminated.

AFFORDABLE CARE ACT means the comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

AGENCY means the Agency for Health Care Administration.

ALLOWABLE FEE SCHEDULE means the dollar amount the Health Plan allows towards the cost for Out-of-Network Covered Services for Point-of-Service (POS) Insured. POS Insured are responsible for any dollar amount a Non-Participating Provider charges in excess of the Allowable Fee Schedule, which is currently based on 150% of the Medicare Fee Schedule. The Allowable Fee Schedule is subject to change without prior notice to affected Covered Persons.

ALLOWANCE OR ALLOWED AMOUNT means the maximum amount which payment will be based for Covered Services. The Allowed Amount may be changed at any time without prior notice or consent of the Insured.

1. In the case of an In-Network Provider located within the Service Area, this amount will be established in accordance with the applicable agreement between that Provider and the Health Plan.

2. In the case of an In-Network Provider located outside of the Service Area, this amount will generally be established in accordance with the negotiated price that has been established between that Provider and the Health Plan.

3. In the case of an Out-of-Network Provider that has not entered into an agreement with the Health Plan to provide access at a discount from the billed amount of that Provider for the specific Covered Services provided to Insureds, the Allowed Amount will be the lesser of that Provider’s actual billed amount for the specific Covered Services or an amount established by the Health Plan that may be based on several factors, including:

   a. Payment for such services under the Medicare program;
   b. Payment often accepted for such services by that Out-of-Network Provider and/or by other Providers, either in Florida or in other comparable market(s), that the Health Plan determines are comparable to the Out-of-Network Provider that provided the specific Covered Services (which may include payment accepted by such Out-of-Network Provider and/or by other Providers as participating Providers in other Provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations);
   c. Payment amounts which are consistent, as determined by the Health Plan, with the Health Plans’ Provider Network strategies (e.g., does not result in payment that encourages Providers participating in the Health Plan Network to become non-participating); and/or
   d. The cost of providing the specific Covered Services.
If a particular Covered Service is not available from any Provider that is in the Health Plan’s Network, as determined by us, the Allowed Amount, whenever Florida Statute §627.6471 applies, means the usual and customary charge(s) of similar Providers in a geographical area established by us.

You may obtain an estimate of the Allowed Amount for particular services by calling the Customer Service phone number included in this Certificate or on your ID card. The fact that we may provide you with such information does not mean that the particular service is a Covered Service. All terms and conditions included in this Certificate apply. You should refer to the Covered Services section of this Certificate and your Schedule of Benefits to determine what is covered and how much we will pay.

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with the Health Plan to provide access at a discount from the billed amount of that Provider, the Allowed Amount for particular services is often substantially below the amount billed by such Out-of-Network Provider for such services. Individuals covered under a POS plan may be responsible for these additional charges.

**AMBULANCE** means a ground or water vehicle, airplane or helicopter properly licensed pursuant to Chapter 401 of the Florida Statutes, or a similar applicable law in another state.

**AMBULATORY SURGICAL CENTER** is a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or other state's applicable law, of which the primary purpose is to provide elective surgical care to a patient, admitted to and discharged from such facility within the same working day, and which is not part of a Hospital.

**APPEAL** means a formal dispute regarding an Adverse Coverage Determination (denial of coverage or application of Cost-Share).

**APPLIED BEHAVIORAL ANALYSIS** means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

**ARTIFICIAL INSEMINATION (AI)** means a medical procedure in which sperm is placed into the female reproductive tract by a qualified Health Care Provider for the purpose of producing a pregnancy.

**AUTHORIZATION FOR SERVICES** means prior approval by the Health Plan to determine Medical Necessity. Authorization is required for certain services to be covered. The Physician requesting the service is required to submit all necessary clinical information along with the request to the Health Plan for review and approval.

**AUTISM SPECTRUM DISORDER** means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association: Autistic disorder, Asperger’s syndrome, or Pervasive developmental disorder not otherwise specified.

**BARIATRIC SURGERY** is surgery to treat obesity, which includes procedures such as gastric banding and gastric bypass procedures.
BEHAVIORAL HEALTH PROVIDER means a licensed organization or professional providing diagnostic, therapeutic or psychological service for behavioral health conditions.

BIRTH CENTER means a facility or institution other than a Hospital or Ambulatory Surgical Center which is properly licensed pursuant to Chapter 383 of the Florida Statues, or similar applicable law of another state, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.

BLOODLESS SURGERY means a surgical procedure requested by an Insured or an Insured’s authorized representative and that is for an Insured who refuses a blood transfusion even though such transfusion may be Medically Necessary due to blood loss during the intra-operative or post-operative period. The surgical procedure uses techniques to avoid blood transfusions.

BONE MARROW TRANSPLANT means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy and non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant or an allogeneic transplant from a medically acceptable related or unrelated donor and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term “Bone Marrow Transplant” includes both the transplantation and the administration of chemotherapy and the chemotherapy drugs. The term “Bone Marrow Transplant” also includes any services or supplies relating to any treatment or therapy involving the use of high-dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other Health Care Provider services or supplies which are rendered in order to treat the effects of, or complications arising from, the use of high-dose or intensive dose chemotherapy or human blood precursor cells (e.g., Hospital room and board and ancillary services).

BRAND NAME PRESCRIPTION DRUG means a Prescription Drug which is marketed or sold by a manufacturer using a trademark or proprietary name, an original or pioneer Drug, or a Drug that is licensed to another company by the Brand Name Drug manufacturer for distribution or sale, whether or not the other company markets the Drug under a generic or other nonproprietary name.

BREAST RECONSTRUCTIVE SURGERY means a surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts.

CALENDAR YEAR means the twelve-month period beginning January 1st and ending December 31st of the same year.

CARDIAC THERAPY means Health Care Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal health function in connection with myocardial infarction, coronary occlusion or coronary bypass surgery.

CERTIFICATE HOLDER means a Certificate Holder who meets and continues to meet all applicable eligibility requirements, pays the required Premiums and who is enrolled and actually covered under the Certificate, other than as a Covered Dependent. See the Eligibility and Effective Dates section of this Certificate.
CERTIFIED NURSE MIDWIFE means a person who is licensed pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state, as an advanced nurse practitioner and who is certified to practice midwifery by the American College of Nurse Midwives.

CERTIFIED REGISTERED NURSE ANESTHETIST means a person who is a properly licensed nurse who is a certified advanced registered nurse practitioner within the nurse anesthetist category pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state.

CLAIM means any request for a Plan benefit or benefits made in accordance with the claims provisions of this Certificate.

COINSURANCE is the sharing of covered health care expenses between the Health Plan and a Covered Person, as specifically set forth in the Schedule of Benefits, if applicable. Coinsurance is expressed as a percentage rather than as a flat dollar amount. After the Calendar Year Deductible requirement is met, if applicable, the Health Plan will pay a percentage of the Allowed Amount for Covered Services, as listed in the Schedule of Benefits attached to this Certificate.

COMPLAINT means any expression of dissatisfaction by an Insured, including dissatisfaction with the administration, claims practices, a provision of services, or quality of care provided by a Provider pursuant to the Health Plan’s Certificate and which is submitted to the Health Plan or to a state agency. A Complaint is part of the informal steps of a Grievance procedure.

CONCURRENT CARE CLAIM occurs where the Health Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two (2) types of concurrent care claims: (1) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments, and (2) where an extension is requested beyond the initially approved period of time or number of treatments.

CONDITION means any sickness, illness, disease, ailment, disorder, infection, Injury, bodily dysfunction, or complications of pregnancy of an Insured.

CONFINEMENT means an approved Medically Necessary covered stay as an inpatient in a Hospital that is:

1. Due to a covered condition; and

2. Authorized by a licensed medical Health Care Provider with admission privileges.

Each "day" of Confinement includes an overnight stay for which a charge is customarily made.

CONTRACTED FEE SCHEDULE means the dollar amount the Health Plan has negotiated with Participating Providers for Covered Services and supplies. Insured are not responsible for any dollar amount a Participating Provider charges in excess of this negotiated fee schedule.

COPAYMENT means the amount payable by the Insured at the time a Covered Service is rendered or, for Group Plans with an attached Prescription Drug Rider, at the time a Prescription Drug is obtained from a Pharmacy. Copayment amounts, if applicable, are set forth
in the Schedule of Benefits and any Rider or Endorsement attached to this Certificate. The Copayment is normally expressed as a flat dollar amount and will apply in full, regardless of the amount of the actual charges.

**COSMETIC SURGERY** means any non-Medically Necessary surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Examples of Cosmetic Surgery include ear piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedure (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

**COST-SHARE** means the amount of the Insured’s financial responsibility as specifically set forth in the Schedule of Benefits and any Rider or Endorsement attached to this Certificate. Cost-Share may include any applicable combination of Deductibles, Coinsurance and Copayments, up to the Out-of-Pocket Maximum Expense Limit.

**COVERED OR COVERAGE** means inclusion of an individual for payment of expenses related to Covered Services under this Group Plan.

**COVERED DEPENDENT** means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under this Group Plan other than as the Certificate Holder. See the “Eligibility Under This Group Plan” subsection of the Eligibility and Effective Dates section of this Certificate for more information.

**COVERED EMPLOYEE** means an Eligible Employee who meets and continues to meet all applicable eligibility requirements and who is enrolled and covered under the Group Plan.

**COVERED PERSON** means a Certificate Holder or a Covered Dependent.

**COVERED PRESCRIPTION DRUG** means, for Group Plans with an attached Prescription Drug Rider, a drug, which, under federal or state law, requires a Prescription and which is covered under the Health Plan’s Pharmacy Program.

**COVERED SERVICES** means those Medically Necessary services and supplies described in the Covered Services section of this Group Plan Certificate and any Rider or Endorsement attached to it.

**CREDITABLE COVERAGE** means health care coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE: the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country); Children’s Health Insurance Program (CHIP); or, a state health insurance high risk pool.

**CUSTODIAL CARE** means non-Medically Necessary care that the Health Plan determines to be provided primarily for the maintenance of an Insured or is designed essentially to assist an Insured in meeting his or her activities of daily living and which is not primarily for its therapeutic value in the treatment of a Sickness or bodily Injury. Examples of activities of daily living include bathing, feeding, dressing, walking, and taking oral medicine.
**DAY SUPPLY** means a maximum quantity per Prescription as defined by the Drug manufacturer's daily dosing recommendations for a 24-hour period.

**DEDUCTIBLE** means the amount of charges, up to the Allowed Amount, for Covered Services or Prescription Drugs (when applicable) which the Insured must actually pay each Calendar Year to an appropriate licensed Health Care Provider before the Health Plan's payment for Covered Services subject to the Deductible begins.

**DEPARTMENT** means the Florida Department of Financial Services, Office of Insurance Regulation.

**DETOXIFICATION** means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent, individual is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician or Psychologist, while keeping the physiological risk to the individual at a minimum.

**DIABETES EDUCATOR** means a person who is properly certified pursuant to Florida law, or a similar applicable law of another state, to supervise diabetes outpatient self-management training and educational services.

**DIALYSIS CENTER** means an outpatient facility certified by the Centers for Medicare & Medicaid Services (CMS) and the Florida Agency for Health Care Administration (or a similar regulatory agency of another state) to provide hemodialysis and peritoneal dialysis services and support.

**DIETITIAN** means a person who is properly licensed pursuant to Florida law, or similar applicable law of another state, to provide nutrition counseling for diabetes outpatient self-management services.

**DISPENSING FEE** means the fee a Pharmacy paid for filling a Prescription, in addition to payment for the Drug.

**DOING BUSINESS AS (d/b/a)** means a formal declaration that a company is conducting business under a different name. Health First Commercial Plans, Inc. is doing business as Florida Hospital Care Advantage.

**DRUG** means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound that has at least one active ingredient that is FDA-approved and has a valid National Drug Code (NDC).

**DURABLE MEDICAL EQUIPMENT (DME)** means equipment furnished by a supplier or a Home Health Agency that: 1) can withstand repeated use; 2) is not available over-the-counter; 3) is primarily and customarily used to serve a medical purpose; 4) not for comfort or convenience; 5) generally is not useful to an individual in the absence of a condition; and 6) is appropriate for use in the home.

**DURABLE MEDICAL EQUIPMENT PROVIDER** means a person or entity that is properly licensed, if applicable, under Florida law (or a similar applicable law of another state) to provide
home medical equipment, oxygen therapy services, or dialysis supplies in the patient’s home under a Physician’s Prescription.

**EFFECTIVE DATE** means, with respect to the Large Employer and to the Insured properly enrolled when coverage first becomes effective, 12:00 a.m. on the date so specified on the Group Plan Information Page. With respect to the Insured who are subsequently enrolled, means 12:00 a.m. on the date on which coverage will commence as specified in the Eligibility and Effective Dates section of this Certificate.

**ELIGIBLE DEPENDENT** means a Certificate Holder’s:

1. Legal Spouse;
2. Natural born, Adopted, Foster, or step child(ren) up through the limiting age described in the Eligibility Under This Group Plan section of this Certificate;
3. A child for whom the Insured has been court-appointed as legal guardian or legal custodian up through the limiting age described in the Eligibility Under This Group Plan section of this Certificate;
4. A Newborn child of a Covered Dependent child if properly enrolled. Coverage for such Newborn child will automatically terminate eighteen (18) months after the birth of the Newborn child.

**ELIGIBLE EMPLOYEE** means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Under This Group Plan section of this Certificate and is eligible to enroll as a Certificate Holder. An individual who is an Eligible Employee is not a Certificate Holder until such individual has actually enrolled with the Health Plan and been accepted for coverage.

**EMERGENCY MEDICAL CONDITION** means:

1. A medical Condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
   a. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.
   b. Serious impairment to bodily functions.
   c. Serious dysfunction of any bodily organ or part.
2. With respect to a pregnant woman:
   a. That there is inadequate time to effect safe transfer to another Hospital prior to delivery;
   b. That a transfer may pose a threat to the health and safety of the patient or fetus;
   or
   c. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

**EMERGENCY SERVICES AND CARE** means medical screening, examination, and evaluation by a Physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Physician, to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a Covered Service by a Physician necessary
to relieve or eliminate the Emergency Medical Condition, within the service capability of a Hospital.

**ENROLLMENT DATE** means the date of enrollment of an individual in this Group Plan for coverage.

**ENTERAL/PARENTERAL NUTRITION THERAPY** involves feeding via a tube into the gastrointestinal tract and does not include nutritional supplements taken orally in any form. Parenteral Nutrition Therapy is the provision of nutrition support intravenously, subcutaneously, intramuscularly or through some other form of injection.

**EXPEDITED APPEAL** means an Appeal that is expedited when applying the standard Appeal resolution time frame and absence thereof would seriously jeopardize the Insured’s health or ability to regain maximum functionality.

**EXPERIMENTAL AND INVESTIGATIONAL TREATMENT** means any evaluation, treatment, therapy, or device which involves the application, administration or use of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by the Health Plan:

1. Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration (FDA) or the Florida Department of Health, and approval for marketing has not, in fact, been given at the time such service is furnished to the Insured;
2. Such evaluation, treatment, therapy or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy or device;
3. Such evaluation, treatment, therapy or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;
4. Evidence considered reliable by the Health Plan showing that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
5. Evidence considered reliable by the Health Plan and which shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
6. Evidence considered reliable by the Health Plan which shows that evaluation, treatment, therapy, or device has not been proven safe and effective for the treatment of the Condition in question, as evidenced in the most recently published medical literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;
7. There is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. Such evaluation, treatment, therapy or device is not the standard treatment therapy or
device utilized by practicing Physicians in treating other patients with the same or
similar Condition.

Reliable evidence, as defined by the Health Plan, may include:

1. Records maintained by Physicians or Hospitals rendering care or treatment to the
Covered Person or other patients with the same or similar Condition;
2. Reports, articles, or written assessments in authoritative medical and scientific
literature published in the United States, Canada, or Great Britain;
3. Published reports, articles, or other literature of the United States Department of
Health and Human Services or the United States Public Health Service, including any
of the National Institutes of Health, or the United States Office of Technology
Assessment;
4. The written protocol or protocols relied upon by the treating Physician or institution or
the protocols of another Physician or institution studying substantially the same
evaluation, treatment, therapy, or device;
5. The written informed consent used by the treating Physician or institution or by
another Physician or institution studying substantially the same evaluation, treatment,
therapy, or device; or
6. The records (including any reports) of any institutional review board of any institution
that has reviewed the evaluation, treatment, therapy or device for the condition in
question.

Note: Health Care Services which are determined by us to be experimental or investigational
are excluded (see the "Exclusions and Limitations" section). In determining whether a Health
Care Service is experimental or investigational, we may also rely on the predominant opinion
among experts, as expressed in the published authoritative literature, that usage of a particular
evaluation, treatment, therapy, or device should be substantially confined to research settings or
that further studies are necessary in order to define safety, toxicity, effectiveness, or
effectiveness compared with standard alternatives.

FACILITY means an institution that provides Health Care Services and could include a Hospital,
Inpatient Rehabilitation Facility, Skilled Nursing Facility, or outpatient center.

FDA means the United States Food and Drug Administration.

FORMULARY means the document then in effect issued by us to Insured with a Group Plan
that includes a Prescription Drug Rider that may designate the following categories of
Prescription Drugs: Preferred Generic Prescription Drugs, Non-Preferred Generic Prescription
Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Brand Name Prescription
Drugs, and Specialty Drugs. The Formulary is subject to change at any time. Please refer to
our website at www.myFHCA.org for the most current Formulary, or you may call our Customer
Service Department.

FOSTER CHILD means a person who is placed in your residence and care under the Foster
Care Program by the Florida Department of Health and Rehabilitation Services in compliance
with Florida Statutes or by a similar regulatory agency of another state in compliance with that
state’s applicable laws.
FRAUDULENT INSURANCE ACT means a person knowingly and with intent to defraud presenting, causing to be presented, or preparing with knowledge or belief that it will be presented, to or by an insurer, self-insurer, self-insurance policy or a claim for payment or other benefit pursuant to any insurance policy that the person knows to contain materially false information concerning any fact material thereto or if the person conceals, for the purpose of misleading another, information concerning any fact material hereto.

GAMETE INTRAFALLOPIN TRANSFER (GIFT) means the direct transfer of a mixture of sperm and eggs into the fallopian tube by a qualified Health Care Provider. Fertilization takes place inside the tube.

GENE TESTING means examining a sample of blood or other body fluid or tissue for biochemical, chromosomal, or genetic markers that indicate the presence or absence of a genetic abnormality.

GENE THERAPY means treatment of disease, Condition or genetic abnormality by replacing, altering or supplementing a gene that is absent or abnormal and is responsible for the disease, Condition or pre-disposition to disease.

GENE COUNSELING means meeting with trained Health Care Professionals before testing begins, when Insured receive the test results and for appropriate post-testing follow-up.

GENERIC PRESCRIPTION DRUG means a Prescription Drug containing the same active ingredients as a Brand Name Prescription drug that either: 1) has been approved by the FDA for sale or distribution as the bioequivalent of a Brand Name Prescription Drug through an abbreviated new Drug application under 21 U.S.C. 355 (j); or 2) is a Prescription Drug that is not a Brand Name Prescription Drug, is legally marketed in the United States and is marketed and sold as a generic competitor to its Brand Name Prescription Drug equivalent. All generic drugs are identified by an "established name" under 21 U.S.C. 352 (e), by a generic name assigned by the United States Adopted Names Council, or by an official or non-proprietary name, and may not necessarily have the same inactive ingredients or appearance as the Brand Name Prescription Drug.

GRIEVANCE means a formal Complaint regarding service issues or the quality of care.

GROUP PLAN means the written document, which is the agreement between the Employer and the Health Plan, whereby coverage and benefits specified herein will be provided to Insured. The Group Plan includes the Certificate of Coverage, all applications, rate letters, face sheets, riders, amendments, addenda exhibits, and Schedule of Benefits that are, or may be, incorporated in this Plan from time to time.

HABILITATIVE/HABILITATION SERVICES are Health Care Services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include Physical and Occupational Therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or outpatient settings. Habilitative Services are not covered under this Group Plan, except as set forth in the Autism Services & Treatment category of the Covered Services section of this Certificate.

HEALTH CARE PROVIDER or PROVIDERS means the Physicians, Physician's assistants, nurses, nurse clinicians, nurse practitioners, pharmacists, marriage and family therapists,
clinical social workers, mental health counselors, speech-language pathologists, audiologists, occupational therapists, respiratory therapists, physical therapists, Ambulance services, Hospitals, Skilled Nursing Facilities, or other Health Care Providers properly licensed in the State of Florida.

**HEALTH CARE SERVICE OR SERVICES** includes treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds and other services actually rendered or supplied by, or at the direction of, a licensed Provider to a specific individual covered under this Group Plan.

**HEALTH INSURANCE ISSUER** means an insurance company, insurance service, or insurance organization which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance.

**HOME HEALTH AGENCY** means a properly licensed agency or organization which provides health services in the home pursuant to Chapter 400 of the Florida Statutes or a similar applicable law of another state.

**HOME HEALTH CARE OR HOME HEALTH CARE SERVICES** means Physician-directed professional, technical and related medical and personal care services provided on an intermittent or part-time basis directly by (or indirectly through) a Home Health Agency in your home or residence. For purposes of this definition, a Hospital, Skilled Nursing Facility, nursing home or other facility will not be considered an individual home or residence.

**HOME HEALTH CARE VISIT** means a period of up to four (4) consecutive hours of Home Health Care Services in a 24-hour period. The time spent by a person providing services under the Home Health Care plan, evaluating the need for, or developing such plan will be a Home Health Care Visit.

**HOSPICE CARE** means a public agency or private organization which is duly licensed by the state of Florida under applicable law, or a similar applicable law of another state, to provide Hospice services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management and supportive care and counseling to terminally ill persons and their families. These services are provided when the individual is judged to have twelve (12) months of life expectancy or less and no longer elects to pursue medical treatment for the terminal illness.

**HOSPITAL** means a facility properly licensed pursuant to Chapter 395 of the Florida statutes, or other state's applicable laws, that offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond twenty-four (24) hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery, obstetrical care or other definitive medical treatment of similar extent.

The term Hospital does not include an Ambulatory Surgical Center; a Skilled Nursing Facility; stand-alone Birthing Centers; facilities for diagnosis, care and treatment of mental and nervous disorders or alcoholism and drug dependency; convalescent, rest or nursing homes; or facilities which primarily provide custodial, education, or rehabilitative care.

**Note:** If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care
Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Services under this Group Plan. It only expands the setting where Covered Services may be performed for coverage purposes.

**HOSPITALISTS** are Physicians who may oversee your care while you are hospitalized. Hospitalists may be Providers other than your Primary Care Physician (PCP) who primarily takes care of you in an Inpatient setting and work with your PCP to coordinate your care.

**HOSPITAL SERVICES** (as expressly limited or excluded by this Group Plan) means those Medically Necessary services for registered bed patients that are (i) generally and customarily provided by acute general Hospitals in the Service Area and (ii) prescribed or directed by your Primary Care Physician and authorized by the Health Plan.

**INJURY** means an accidental bodily injury that:

1. Is caused by a sudden, unintentional, and unexpected event or force;
2. Is sustained while the Insured's coverage is in force; and
3. Results in loss directly and independently of all other causes.

**INFERTILE** or **INFERTILITY** means the condition of a presumably healthy Insured who is unable to conceive or produce conception after one (1) year or more of timed, unprotected coitus, or twelve (12) cycles of artificial insemination (for an Insured less than thirty-five (35) years of age), or six (6) months or more of timed, unprotected coitus, or six (6) cycles of artificial insemination (for an Insured twenty-five (25) years of age or older). Infertile or infertility does not include conditions for a male Insured when the cause is a vasectomy or orchiectomy or for a female Insured when the cause is a tubal ligation or hysterectomy with or without surgical reversal.

**IN-NETWORK** means, when used in reference to Covered Services, the level of benefits payable to an In-Network Provider as designated on your Schedule of Benefits under the heading “In-Network”. Otherwise, In-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is an In-Network Provider under the terms of this Group Plan.

**IN-NETWORK PROVIDER** means any Health Care Provider who, at the time Covered Services were rendered to you, was under contract with the Health Plan to participate in our Network and included in the panel of Providers designated by the Health Plan as “In-Network” for your specific plan. (Please refer to your Provider Directory.) For payment purposes under this Group Plan only, the term In-Network Provider also refers, when applicable, to any Health Care Provider located outside of our Service Area who or which, at the time Health Care Services were rendered to you, participated as a Health Plan Provider.

**INPATIENT** means those Medically Necessary services that are provided in a facility that has licensed beds and is referred to as an acute care facility. The person who is treated as an Inpatient remains in the facility both days and nights for the period of service.

**INPATIENT REHABILITATION FACILITY** means a freestanding Inpatient Rehabilitation Facility or rehabilitation unit of a licensed Hospital certified under Titles XVIII and XIX of the Social Security Act that is under contract with the Health Plan.
INSURED means the Eligible Employee or any Eligible Dependent included for coverage under this Group Plan. Eligibility requirements for employees and dependents are specified in the “Eligibility Under this Group Plan” section of this Certificate. An Insured may also be referred to as Certificate Holder or Covered Person.

IN VITRO FERTILIZATION (IVF) means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to the woman’s uterus.

LARGE EMPLOYER OR EMPLOYER means the employer who has signed a contract with the Health Plan allowing this group health insurance coverage to be provided. To be eligible for coverage, a Large Employer means in connection with a health benefit plan with respect to a Calendar Year and a plan year, any firm, corporation, partnership, or association that is actively engaged in business and is not defined as a Small Employer under FS 627.6699.

LICENSED PRACTICAL NURSE means a person properly licensed to practice practical nursing pursuant to Chapter 464 of the Florida Statutes, or a similar applicable law of another state.

MAIL ORDER PHARMACY means a Pharmacy that has signed a Mail Services Prescription Drug Agreement with us. Health First Family Pharmacy and MedVantx are participating mail order pharmacies.

MASTECTOMY means the removal of all or part of a breast for Medically Necessary reasons as determined by a licensed Physician.

MATERIAL MISREPRESENTATION means the omission, concealment of facts or incorrect statements made on any application or enrollment forms by the Large Employer, an applicant or Covered Person which would have affected our decision to issue this Group Plan, issuance of different benefits, or issuance of this Group Plan only at a higher rate had they been known.

MEDICAL COMMUNITY means as a majority of Physicians who are Board Certified in the appropriate specialty.

MEDICAL EMERGENCY means the existence of a medical Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and the unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

MEDICAL GROUP means any individual practice association or group of licensed doctors of medicine or osteopathy.

MEDICAL LITERATURE means scientific studies published in a United States peer-reviewed national professional journal.

MEDICALLY NECESSARY OR MEDICAL NECESSITY means a medical service or supply that is required for the identification, treatment, or management of a Condition. A Condition is Medically Necessary if it is:
1. Consistent with the symptom, diagnosis, and treatment of the Insured's Condition;
2. Widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence;
3. Universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment;
4. Not experimental or investigational;
5. Not for cosmetic purposes;
6. Not primarily for the convenience of the Insured, the Insured's family, the Physician, or other Provider; and
7. The most appropriate level of service, care or supply which can safely be provided to the Insured. If the safety and the efficacy of all alternatives are equal, the Health Plan will provide coverage for the least costly alternative. When applied to Inpatient care, Medically Necessary further means that the services cannot be safely provided to the Insured in an alternative setting.

**Note:** It is important to remember that any review of Medical Necessity by us is solely for the purpose of determining coverage or benefits under this Group Plan and not for the purpose of recommending or providing medical care. In this respect, we may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining, among other things, whether a service provided or proposed meets the definition of Medical Necessity in this Group Plan as determined by us. In applying the definition of Medical Necessity in this Group Plan, we may apply our coverage and payment guidelines then in effect. You are free to obtain a service even if we deny coverage because the service is not Medically Necessary; however, you will be solely responsible for paying for the service.

**MEDICARE** means the health insurance programs under Title XVIII of the United States Social Security Act of 1965, as then constituted or as later amended.

**MEMBER** means an Eligible Employee or Eligible Dependent covered under this Group Plan.

**MENTAL HEALTH PROFESSIONAL** means a person properly licensed to provide Mental Health Services, pursuant to Chapter 491 of the Florida Statues or a similar applicable law of another state. This professional may be a clinical social worker, mental health counselor or marriage and family therapist. A Mental Health Professional does not include members of any religious denomination who provide counseling services.

**MENTAL AND NERVOUS DISORDER** means any disorder set forth in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM) or their equivalents in the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder. Examples include attention deficit hyperactivity, bipolar affective disorder, Autism, mental retardation and Tourette's disorder.

**MIDWIFE** means a person properly licensed to practice midwifery pursuant to Chapter 467 of the Florida Statutes, or a similar applicable law of another state.

**MONETARY RECOVERY** means payment from a third party, including any insurer as a result of payment of benefits, settlement, verdict, judgment, or arbitration award or recovery by any
other means in money or in kind from or no behalf of a party held responsible for an Injury or illness to a Covered Person.

**NATIONAL DRUG CODE (NDC)** means the universal code that identifies the drug dispensed. There are three (3) parts of the NDC, which are as follows: the labeler code (first five digits), product code (middle four digits), and the package code (last two digits).

**NETWORK** means the same definition as Participating Provider.

**NEWBORN** means a child who is within twenty-eight (28) days of birth.

**NON-PARTICIPATING PHARMACY** means a Pharmacy that has not agreed to participate in our Health Plan Pharmacy Network.

**NON-PARTICIPATING PROVIDER** means a non-participating Health Care Provider (Hospital, a Physician, Physician extender, Pharmacy, or other Provider) who has not made an agreement with the Health Plan to provide services to Insured and is not published in the Provider Directory as participating.

**NON-PREFERRED PRESCRIPTION DRUG** means a Prescription Drug that is not included on the preferred Formulary tier then in effect.

**NURSING SERVICES** means services that are provided by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or a Licensed Vocational Nurse (L.V.N.) who is:

1. Acting within the scope of that person's license; or
2. Authorized by a Physician; and
3. Not a member of the Insured's immediate family.

**OCCUPATIONAL THERAPIST** means a person properly licensed to practice Occupational Therapy pursuant to Chapter 468 of the Florida Statutes, or a similar applicable law of another state.

**OCCUPATIONAL THERAPY** means a treatment that follows an illness or Injury and is designed to help a patient learn to use a newly restored or previously impaired function.

**OPEN ACCESS** means an Insured may access Covered Services from any participating Specialist without a referral from the Primary Care Physician. Note: Certain Specialists will not accept direct appointments from an Insured and require a referral to be seen.

**ORTHOTIC DEVICE** means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.

**OUT-OF-NETWORK** means, when used in reference to Covered Services, the level of benefits payable to an Out-of-Network Provider as designated on your Schedule of Benefits under the heading "Out-of-Network". Otherwise, Out-of-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is not an In-Network Provider under the terms of this Group Plan.

**OUT-OF-NETWORK PROVIDER** means a Provider who, at the time Health Care Services were rendered, did not have a contract with us to participate in the Health Plan’s Network.
OUT-OF-POCKET MAXIMUM LIMIT means the maximum amount of covered expenses each Insured pays every Calendar Year before benefits are payable at one hundred percent (100%) for the remainder of the Calendar Year. Certain expenditures may be excluded from the calculation, such as expenses related to charges for services not covered by this Group Plan and expenses that relate to services that exceed specific treatment limits.

OUTPATIENT REHABILITATION FACILITY means an entity which renders, through Providers properly licensed pursuant to Florida law, or the similar law or laws of another state, any of the following: outpatient Physical Therapy; outpatient Speech Therapy; outpatient Occupational Therapy; and outpatient cardiac rehabilitation therapy for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet our criteria for eligibility as an Outpatient Rehabilitation Facility. The term Outpatient Rehabilitation Facility, as used herein, shall not include any Hospital, including a general acute care Hospital, or any separately organized unit of a Hospital which provides comprehensive medical rehabilitation Inpatient services or rehabilitation outpatient services, including a Class III "specialty rehabilitation Hospital" described in Chapter 59A, Florida Administrative Code or the similar law or laws of another state.

OUTPATIENT SURGERY includes any procedure performed in an Ambulatory Surgery Center or Hospital facility, including diagnostic tests or any other minor procedures.

OVER-THE-COUNTER (OTC) DRUG means a drug that is safe and effective for use by the general public, as determined by the FDA, and can be obtained without a Prescription.

PAIN MANAGEMENT includes services for pain assessment, medication, Physical Therapy, biofeedback, and/or counseling. Pain rehabilitation programs are programs featuring multidisciplinary services directed toward helping those with chronic pain to reduce or limit their pain.

PARTIAL DISABILITY means having a Condition from an illness or Injury that prevents the individual from performing some part or all of the “major,” “important,” or “essential” duties of one’s employment or occupation and the individual is under the regular care of a Physician. Determination of Partial Disability shall be made by the Physician on the basis of a medical examination of the Insured and upon concurrence by the Health Plan’s Medical Director.

PARTIAL HOSPITALIZATION means treatment in which an individual receives at least seven (7) hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

PARTICIPATING PHARMACY means, as to pharmacies located in the Service Area, a Pharmacy that has signed a Participating Pharmacy Provider Agreement with us to participate in the Health Plan’s Pharmacy Network.

PARTICIPATING PROVIDER means, or refers to, the preferred Provider Network established and so designated by the Health Plan which is available to Covered Persons under this Group Plan. This includes a participating Hospital, a participating Physician, or other participating Health Care Provider who has made an agreement with the Health Plan to provide services to Covered Persons and is published as such in the Health Plan’s Provider Directory.
PHARMACY means an establishment licensed as a Pharmacy pursuant to Chapter 465 of the Florida Statutes, or a similar law of another state, where Pharmacists dispense Prescription Drugs.

PHYSICAL THERAPIST means a person properly licensed to practice Physical Therapy pursuant to Chapter 486 of the Florida Statutes, or a similar applicable law of another state.

PHYSICAL THERAPY means the treatment of disease or Injury by physical or mechanical means as defined in Chapter 486 of the Florida Statutes or a similar applicable law of another state. Such therapy may include traction, active or passive exercises, or heat therapy.

PHYSICIAN means an individual who is (a) licensed to practice medicine and/or surgery, or (b) any other licensed practitioner of the healing arts who is practicing within the scope of his or her license and whose services are required to be covered under this Group Plan by the laws of the jurisdiction where treatment is given or is a partnership or professional association or corporation of such individuals in subsection (a) or (b), is a person properly licensed to practice medicine pursuant to Florida law, or another state's applicable laws, including:

1. Doctors of Medicine (MD) or Doctors of Osteopathy (D.O.);
2. Doctors of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.);
3. Doctors of Chiropractic (D.C.);
4. Doctors of Optometry (O.D.) or Ophthalmology; and
5. Doctors of Podiatry (D.P.M.).

PHYSICIAN ASSISTANT means a person properly licensed pursuant to Chapter 458 of the Florida Statutes, or a similar applicable law of another state.

POINT-OF-SERVICE (POS) means a benefit plan under which an Insured has the right to access certain Medically Necessary Covered Services from Non-Participating Providers without a referral from the HMO Primary Care Physician or the Health Plan. Certain services require authorization from the Health Plan to determine Medical Necessity.

POST-SERVICE CLAIM means any request or application for coverage or benefits for a service that has been provided to you. A Post-Service Claim is any claim for a benefit under the Plan that is not a Pre-Service Claim, an Urgent Care Claim, or a Concurrent Care Claim.

PREFERRED PRESCRIPTION DRUG means a Prescription Drug on one of the preferred Formulary tiers then in effect. The preferred tiers are contained within the Formulary.

PREMIUM means the amount established by the Health Plan to be paid to the Health Plan by the Large Employer or on behalf of the Large Employer in consideration of the benefits provided under this Group Plan.

PRESCRIPTION means an order for drugs, services or supplies by a Physician or other Health Care Provider authorized by law to prescribe such drugs, services or supplies.

PRESCRIPTION DRUG means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound which can only be dispensed pursuant to a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription".
PRE-SERVICE CLAIM means a claim the Health Plan specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves Urgent Care. Benefits under the Group Plan that require approval in advance are specifically noted in the Health Plan’s Authorization List as being subject to Prior Authorization.

PRIMARY CARE PHYSICIAN (PCP) means a Family Practitioner, Internist, Pediatrician or their Physician Extender (i.e., Physician Assistant or Nurse Practitioner) licensed to provide, prescribe, and authorize care and treatment for the Insured. A current listing of contracted Primary Care Physicians is published in the Plan’s Provider Directory.

PROSTHETIC DEVICE means a device which replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or malfunctioning body part or organ.

PROSTHETIST/ORTHOTIST means a person or entity that is properly licensed, if applicable, under Florida law, or a similar applicable law of another state, to provide services consisting of the design and fabrication of medical devices such as braces, splints, and artificial limbs prescribed by a Physician.

PROVIDER means any facility, person or entity recognized for payment by the Health Plan under this Group Plan.

PROVIDER DIRECTORY means a listing of all contracted Participating Providers for the Plan of which you are an Insured. Copies of this Directory are available on our website, www.myFHCA.org, and will be furnished to you upon request.

PSYCHIATRIC FACILITY means a facility properly licensed under Florida law, or similar applicable law of another state, to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For the purposes of this Group Plan, a Psychiatric Facility is not a Hospital or a Substance Abuse Facility.

PSYCHOLOGIST means a person properly licensed to practice psychology pursuant to Chapter 490 of the Florida Statutes or a similar applicable law of another state.

REGISTERED NURSE means a person properly licensed to practice professional nursing pursuant to Chapter 464 of the Florida Statutes or a similar applicable law of another state.

REGISTERED NURSE FIRST ASSISTANCE means a person properly licensed to perform surgical first assisting services pursuant to Chapter 464 of the Florida Statutes or a similar applicable law of another state.

RESPITE CARE means care furnished during a period of time when the Insured’s family or usual caretaker cannot, or will not, attend to the Insured’s needs.

REHABILITATION SERVICES means services for the purpose of restoring function lost due to illness, Injury or surgical procedures, including cardiac rehabilitation, pulmonary rehabilitation, Occupational Therapy, Speech Therapy and Physical Therapy.
REHABILITATION THERAPY means the short-term physical, speech, hearing, or respiratory therapy that a participating Physician and the Medical Director have determined will result in a significant improvement in the Condition.

RECONSTRUCTIVE SURGERY means surgery that is incidental to an Injury, Sickness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. For the purpose of coverage under this Group Plan, the initial breast reconstruction following a Mastectomy is considered to be Reconstructive Surgery. A congenital anomaly is a defective development or formation of a part of the body, which defect is determined by a Physician to have been present at the time of birth.

RIDER means any attached written description of additional covered Health Care Services not described in this Certificate. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Certificate except for those that are specifically amended in the Rider.

SELF-ADMINISTERED INJECTABLE PRESCRIPTION DRUG means an FDA-approved injectable Prescription Drug that you may administer to yourself, as recommended by a Physician, by means of injection, excluding insulin.

SERVICE AREA means the geographic area in which the Health Plan is authorized to provide health services as approved by the Agency for Health Care Administration. The Health Plan Service Area for this Group Plan is all of Volusia and Flagler Counties.

SICKNESS means bodily disease for which expenses are incurred while coverage under this Group Plan is in force.

SKILLED NURSING CARE means skilled nursing services, above the level of Custodial Care, which is Medically Necessary, ordered by a Provider, and provided by a licensed Skilled Nursing Facility.

SKILLED NURSING FACILITY means an institution that meets all of the following requirements:

1. It must provide treatment to restore the health of sick or injured persons.
2. The treatment must be given by or supervised by a Physician. Nursing services must be given by or supervised by a Registered Nurse.
3. It must not primarily be a place of rest, a nursing home or place of care for senility, drug addiction, alcoholism, mental retardation, psychiatric disorders, chronic brain syndromes or a place for the aged.
4. It must be licensed as a Skilled Nursing Facility by the state of Florida or a similar applicable law of another state.
5. It must be accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by the Health Plan.

SOUND NATURAL TEETH means teeth that are whole or properly restored (restoration with amalgams, resin or composite only); are without impairment, periodontal, or other conditions;
and are not in need of services provided for any reason other than an Accidental Dental Injury. Teeth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated with endodontics are not Sound Natural Teeth.

**SPECIALIST(S)** means a Physician or their Physician Extender (i.e., Physician Assistant or Nurse Practitioner) who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

**SPECIALTY DRUG** means an FDA-approved Prescription Drug that has been designated by us as a Specialty Drug due to requirements such as special handling, storage, training, distribution, and management of the therapy.

**SPEECH THERAPIST** means a person properly licensed to practice Speech Therapy pursuant to Chapter 468 of the Florida Statutes or a similar applicable law of another state.

**SPEECH THERAPY** means the treatment of speech and language disorders by a Speech Therapist, including language assessment and language restorative therapy services.

**SPOUSE** means any individuals who are lawfully married under any state law, including individuals married to a person of the same sex who were legally married in a state that recognizes such marriages but who are domiciled in a state that does not recognize such marriages.

**SUBSTANCE ABUSE FACILITY** means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide necessary care and treatment for Substance Dependency. For the purposes of this Group Plan, a Substance Abuse Facility is not a Hospital or a Psychiatric Facility, as defined herein.

**SUBSTANCE DEPENDENCY** means a condition where a person’s alcohol or drug use injures his or her health, interferes with his or her social or economic functioning, or causes the individual to lose self-control.

**TRANSPLANT** means a replacement of solid organs, stem cells, bone marrow or tissue.

**TOTALLY DISABLED** means for an adult Insured, having a Condition from an illness or Injury that prevents the individual from engaging in any employment or occupation for which the individual is or may become qualified by of education, training, or experience and the individual is under the regular care of a Primary Care Physician. For Insureds who are children, totally disabled means a persistent physical impairment resulting from an Injury or illness. Determination of total disability shall be made by the Primary Care Physician on the basis a medical examination of the Insured and upon concurrence by the Health Plan’s Medical Director. The period of total disability must be expected to extend for at least six (6) months.

**URGENT CARE** means medical screening, examination, and evaluation received in an Urgent Care Center, or rendered in a Physician’s office for Urgent Care after-hours, and the Covered Services for those Conditions which, although not life-threatening, could result in serious health consequences if not treated within twelve (12) hours and were unforeseeable prior to leaving the Service Area.

**URGENT CARE CENTER** means a facility properly licensed that: 1) is available to provide services to patients at least sixty (60) hours per week with at least twenty-five (25) of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; 2) posts instructions for
individuals seeking Health Care Services, in a conspicuous public place, as to where to obtain such services when the Urgent Care Center is closed; 3) employs or contracts with at least one or more Board Certified or Board Eligible Physicians and Registered Nurses (RNs) who are physically present during all hours of operation (Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children); and 4) maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations.

**URGENT CARE CLAIM** means a special type of Pre-Service Claim. A claim involving Urgent Care is any Pre-Service Claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to Pre-Service Claims could seriously jeopardize the claimant's life or health or ability to regain maximum function or would—in the opinion of a Physician with knowledge of the claimant's medical Condition—subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

**UTILIZATION MANAGEMENT/QUALITY MANAGEMENT (UM/QM) PROTOCOLS** means those procedures adopted by the Health Plan to ensure that the Covered Services provided to Insured are Medically Necessary and that preventive, acute and tertiary care are provided to Covered Persons consistent with the provision of quality care in the most cost-effective manner available.

**WAITING PERIOD** shall mean the period, if any, that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of this Group Plan.

**WE, US, OUR** means Health First Commercial Plans, Inc. d/b/a Florida Hospital Care Advantage.

**YOU, YOURS** means the Eligible Employee and Eligible Dependents who are Insured under this Group Plan.

**XI. NOTICES**

**A. WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998**

As required by the Women’s Health and Cancer Rights Act of 1998, the Health Plan provides coverage under this Group Plan for Mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a Mastectomy (including lymphedema). If an Insured is receiving services in connection with a Mastectomy, coverage is also provided for the following, as the Insured and the attending Physician determine to be appropriate:

1. All stages of reconstruction of the breast on which the Mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and treatment of physical complications of the Mastectomy, including lymphedema.
The amount the Insured must pay for Covered Services is the same as are required for any other Covered Service. Limitations on coverage are the same as for any other Covered Service.

**B. STATEMENT OF RIGHTS UNDER THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT**

Under federal law, the Plan Sponsor generally may not restrict coverage for any Hospital length of stay, in connection with childbirth for the mother or Newborn child, to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the Plan Sponsor may pay for a shorter stay if the attending Provider (Physician, nurse Midwife or Physician Assistant), after consultation with the mother, discharges the mother or Newborn child earlier than the forty-eight (48) or ninety-six (96) hours described above.

Also, under federal law, the Plan Sponsor may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or Newborn than any earlier portion of the stay. Complications of pregnancy must be treated the same as any other illness.

In addition, the Plan Sponsor may not, under federal law, require that a Physician or other Health Care Provider provide prior notification before prescribing a length of stay of up to forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a delivery by cesarean section.

**C. STATEMENT OF EMPLOYEE RETIREMENT SECURITY ACT OF 1974**

If you participate in the Health Plan through an employer that is not a religious organization or political subdivision, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

**Receive Information about Your Plan and Benefits**

1. **Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.**

2. **Obtain, upon written request to the plan administrator (employer), copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.**

3. **Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each Certificate Holder with a copy of this summary annual report.**
Continue Group Health Plan Coverage

1. Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Group Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

2. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your
telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

D. FLORIDA AGENCY FOR HEALTHCARE ADMINISTRATION (AHCA)

AHCA is in the process of developing a long-range plan making available performance outcome and financial comparison data for consumers to compare health care services. The Health Plan will incorporate a link on the Health Plan’s website to the AHCA information that is required by law to be available no later than March 1, 2006. The Health Plan’s website address is: www.myFHCA.org.

E. MICHELLE’S LAW

Michelle’s Law, a federal law (P.L. 110-381) enacted on October 9, 2008, became effective January 1, 2010. This law provides for continuation of dependent eligibility because of a reduction in full-time class status or a medical leave of absence from school. The leave of absence or reduction in hours must be Medically Necessary and must commence while the eligible student is suffering from a serious illness or injury that would otherwise terminate coverage under the plan. Other requirements exist in order for these provisions to apply (i.e. the student must have been enrolled in the group health plan before the first day of the leave). There must also be supporting written certification by a participating Physician indicating that the student meets the criteria for the change in enrollment status. The coverage must be extended for at least one (1) year; however, coverage may end earlier for certain reasons, such as the student aging out of the plan under the Group Plan’s dependent eligibility definitions.

XII. INSURED’S RIGHTS AND RESPONSIBILITIES

We value our relationship with you and believe that setting clear expectations about our partnership is a critical part of earning your trust. The following rights and responsibilities represent the cornerstone of our successful future, and we encourage you to become familiar with them.

As a Member, you have the right:

1. To receive these rights and responsibilities, as well as other information about your health plan and its benefits, services, and providers.

2. To be treated with respect and recognition of your dignity and right to privacy. (See our Notice of Privacy Practices for additional information on how we protect your information.)

3. To participate with practitioners in decisions involving your health care, considering ethical, cultural, and spiritual beliefs, unless concern for your health indicates otherwise.

4. To have a candid discussion of appropriate or Medically Necessary treatment options for your Conditions, regardless of cost or benefit coverage. You have the right to receive this information in terms you understand.
5. To receive a prompt response when you ask questions or request information.

6. To be informed of who is providing your medical care and who is responsible for your care.

7. To be informed if your Health Care Provider plans to use experimental treatment for your care. You have the right to refuse to participate in such experimental treatment.

8. To receive a reasonable estimate of charges for your medical care and a copy of an itemized bill, reasonably clear and understandable, and have the charges explained to you.

9. To receive information about Copayments and fees that you are responsible to pay.

10. To know what patient support services are available to you, including whether an interpreter is available if you do not speak English.

11. To be informed about your diagnosis, testing, treatments, and prognoses. When concern for your health makes it inadvisable to give such information to you, such information will be made available to an individual designated by you or to a legally authorized individual.

12. To be informed about consent to treatment, your right to refuse treatment to the extent permitted by law, and the consequences of your refusal. When refusal prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the Member may be terminated by the Provider upon reasonable notice.

13. To receive quality, timely health care with respect and compassion regardless of race, age, sex, religious beliefs, source of payment, health status, or need for health services.

14. To receive treatment for any Emergency Medical Condition that will get worse from failure to obtain the treatment.

15. To determine the course of your treatment by issuing "advance directives." In accordance with the federal law titled "Patient Self-Determination Act" and the Florida Statute Chapter 765 titled "Health Care Advance Directives," you can make future health care decisions now with these types of advance directives:

   a. The "living will" states which medical treatments you would accept or refuse if you became permanently unconscious or terminally ill and unable to communicate.

   b. The "durable power of attorney for health care" or "designation of a healthcare surrogate" allow you to appoint someone else to make decisions regarding your health care when you are temporarily or permanently unable to communicate.

16. To have your medical records kept private, except when you provide your consent or when permitted by law.
17. To choose a primary doctor to coordinate your care and to change your doctor at any time.

18. To receive information about our quality improvement programs, including the progress being made.

19. To make recommendations regarding our Member rights and responsibilities policies.

20. To receive information and necessary counseling on the availability of known financial resources for your care.

21. To know what rules and regulations apply to your conduct.

22. To voice concerns or Appeals about your benefits, our service, or the care provided.

Additionally, you have the responsibility:

1. To understand your benefits and plan guidelines.

2. To supply accurate and complete information, including unexpected changes in your health Condition (to the extent possible), that your plan and your Providers need in order to provide you care.

3. To provide your doctor, to the best of your knowledge, accurate and complete information about any current medical complaints, past medical history and any other information relating to your health.

4. To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

5. To follow the plans and instructions for care that you have agreed on with your Providers.

6. To be responsible for your actions if you refuse treatment or do not follow your Health Care Provider’s instructions.

7. To follow the Provider's rules and regulations affecting patient care and conduct, including keeping your appointments and arriving promptly, and notifying your Physician if you're unable to keep a scheduled appointment in a timely fashion.

8. To pay your Cost-Share or any other applicable fees according to your plan documents.

9. To notify us of any changes in your address, telephone number, or eligibility status.

If you are enrolled in an HMO plan, to use the designated participating Primary Care Physicians, Specialists, medical facilities and suppliers (except for Emergency Care).
Nondiscrimination Notice

Florida Hospital Care Advantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Florida Hospital Care Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Hospital Care Advantage:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please contact Sherri Wynn.

If you believe that Florida Hospital Care Advantage has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Sherri Wynn, ADA/Section 504 Coordinator, 6450 US Highway 1, Rockledge, FL 32955, 321-434-4521, 1-800-955-8771 (TTY), Fax: 321-434-4362, Sherri.Wynn@health-first.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance Sherri Wynn, ADA/Section 504 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).


Florida Hospital Care Advantage is underwritten by Health First Commercial Plans, Inc. Health First Commercial Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

FHCA Large Group HMO_POS Nondiscrimination Notice (10_2016)
English:
If you, or someone you’re helping, has questions about Florida Hospital Care Advantage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 844-522-5279.

Spanish:
En caso que usted, o alguien a quien usted ayude, tenga cualquier duda o pregunta acerca de Florida Hospital Care Advantage, usted tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 844-522-5279.

Haitian Creole:
Si oumenm oswa yon moun w ap ede gen kesyon konsènan Florida Hospital Care Advantage, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 844-522-5279.

Vietnamese:
Nếu Quý vị, hay người mà Quý vị đang giúp đỡ, có câu hỏi về Florida Hospital Care Advantage thì Quý vị có quyền được trợ giúp và được biết thêm tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, xin gọi số 844-522-5279.

Portuguese:
Você ou alguém que você estiver ajudando tem o direito de tirar dúvidas e obter informações sobre os Florida Hospital Care Advantage no seu idioma e sem custos. Para falar com um tradutor, ligue para 844-522-5279.

Chinese:
如果您，或是您正在協助的對象，有與Florida Hospital Care Advantage相關的問題，您有權以您的母語免費取得幫助和資訊。請致電844-522-5279與翻譯員洽談。

French:
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Florida Hospital Care Advantage, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 844-522-5279.

Tagalog:
Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Florida Hospital Care Advantage, may karapatan ka na humingi ng tulong at impormasyon sa iyong wika nang libre. Upang makausap ang isang tagasalin, tumawag sa 844-522-5279.

Russian:
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Florida Hospital Care Advantage, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 844-522-5279.

Arabic:
إن كان لديك أو لِدى شخص تساعدته أسئلة بخصوص Florida Hospital Care Advantage，则您有权免费获取您的语言帮助和信息。请致电844-522-5279与翻译员联系。
Italian:
Se lei o qualcuno che sta aiutando avete domande su Florida Hospital Care Advantage, ha il diritto di ottenere aiuto e informazioni nella sua lingua gratuitamente. Per parlare con un interprete, può chiamare il numero 844-522-5279.

German:
Falls Sie oder jemand, dem Sie helfen, Fragen zum Florida Hospital Care Advantage haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 844-522-5279 an.

Korean:
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Florida Hospital Care Advantage에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 844-522-5279로 전화하십시오.

Polish:
Jeśli Ty lub osoba, której pomagasz, macie pytania na temat Florida Hospital Care Advantage, macie Państwo prawo do bezpłatnego uzyskania informacji i pomocy w języku ojczystym. Aby porozmawiać z tłumaczem, prosimy zadzwonić pod numer 844-522-5279.

Gujarati:
જો તમે અથવા તમે કોઇને મદદ કરી રહી રહ્યો હોય તેમાંથી કોઈને ફ્લોરિડા હોસ્પિટલ કરે એડવાંટેજ વિશે પ્લાને હોય તો તમને તમારી ભાષામાં વિના મુલાકાત મદદ અને માહતી મેળવવાનો અધિકાર છે. હલાકી સાથે વાત કરવા માટે 844-522-5279 પર કૉલ કરો.

Thai:
หากคุณหรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Florida Hospital Care Advantage คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการพูดคุยกับตัว โปรดโทรศัพท์ 844-522-5279.