Welcome!

HMO/POS Individual
Evidence of Coverage

Provided by:

Florida Hospital Care Advantage

Underwritten by Health First Health 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
INDIVIDUAL HMO/POS POLICYHOLDER
EVIDENCE OF COVERAGE
With Integrated Prescription Drug Coverage

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.

IMPORTANT NOTICE
Issuance of this Evidence of Coverage is based on your answers to the questions on your application or HealthCare.gov account. If, for any reason, your answers are incorrect, contact us, or the Marketplace for HealthCare.gov submissions, within ten (10) calendar days. Omissions or misstatements on the application could cause your Claim to be denied or your Policy to be rescinded.

This Individual Policyholder Agreement (hereinafter referred to as the “Agreement”) issued by Health First Health Plans, Inc. d/b/a Florida Hospital Care Advantage, (hereinafter referred to as the “Health Plan”) to a Policyholder (hereinafter referred to as “Policyholder” or “Insured”), sets forth the basis on which an eligible person is provided with Coverage for Health Care Services and benefits. Upon acceptance for Coverage, a Policyholder is entitled to Covered Services provided by the Health Plan commencing with each Policyholder’s Coverage Effective Date. Coverage is not provided for any services rendered prior to the Effective Date of Coverage or after the termination date of this Agreement. During the term of this Agreement, we agree to provide the health insurance Coverage and benefits specifically provided in this Agreement to Covered individuals, subject to all applicable terms, conditions, limitations and exclusions.

Ten Day Right to Examine and Return Policy
Please read your policy carefully. If, for any reason, you are not satisfied, you may return your Policy to us within ten (10) calendar days after receiving it. If returned, the Policy will be void from its beginning, and any Premium paid will be refunded.

Guaranteed Renewable for Life – Premiums Subject to Change
This Agreement is renewable as long as you live, provided you continue to pay Premiums when due. Premiums are based on your attained age. The Premium may change if a new table of rates is applicable to the Agreement. The change in the table of rates will apply to all Covered Persons in the same class on the date of the change. Class is defined as location (state and zip code of residence), age, family size, tobacco use, and plan category. Any Premium change will be filed and approved by the Florida Office of Insurance Regulation (OIR) and the Centers for Medicare & Medicaid Services (CMS) prior to any Premium adjustment. This Agreement can be rescinded or canceled if you have made a fraudulent or Material Misrepresentation or omission on your Application or, at our discretion, we may elect to cancel the Agreement with forty-five (45) calendar days’ prior written notice. This Agreement can be canceled if we terminate the Policy form for everyone Covered by it. You will be notified at least forty-five (45) calendar days in advance before any change in the table of rates or at least ninety (90) calendar days before termination of the Policy form.

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

THIS PLAN INCLUDES A DEDUCTIBLE PROVISION

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

FHCA Individual HMO_POS Evidence of Coverage (1_2016) R0615
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I. HOW TO USE YOUR AGREEMENT

This is your Agreement. You should read it carefully before you need Health Care Services. It contains valuable information about:

- Your Health Plan benefits;
- What Health Care Services are Covered;
- What Health Care Services are excluded or not Covered;
- Our Coverage and any payment rules;
- How and when to file a Claim;
- How much, and under what circumstances, the Health Plan will pay;
- What you will have to pay as your share; and
- Other important information, including when benefits may change, how and when Coverage stops, how we will coordinate benefits with other policies or plans, our subrogation rights, and our right of reimbursement.

Please refer to your Schedule of Benefits included in this Agreement to determine how much you have to pay for particular Health Care Services.

When reading your Agreement, please remember:

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

2. The headings of sections contained in this Agreement 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 Policyholder 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 Policyholder or solely to your Covered Dependent(s) will be noted as such.

4. References to "we", "us", and "our" throughout refer to Health First Health 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

A. ELIGIBILITY

ELIGIBILITY REQUIREMENTS FOR POLICYHOLDERS

Any individual who meets and continues to meet our eligibility requirements described in the Agreement shall be entitled to apply for Coverage with us under this Agreement. These eligibility requirements are binding upon you and/or your eligible family members. We may require applicable documentation that an individual meets and continues to meet the eligibility requirements (e.g., copies of a court order naming the Policyholder as the legal guardian, proof of residency, or appropriate Adoption documentation described in the “Dependent Enrollment” subsection).

In order to enroll in this individual health benefit plan, primary Applicants must meet each of the following requirements:

1. Must be a U.S. citizen or national (or be lawfully present).
2. Must not already be enrolled in a Medicare plan at the time of the application.
3. Must continually and permanently reside within the Health Plan’s Service Area.
4. Must submit a completed and signed Enrollment Application, including all requested information, or apply through the Health Insurance Marketplace.
5. Must pay the required Premiums.
6. Must not be currently incarcerated.

In addition to the eligibility requirements listed above, Applicants enrolling in a Catastrophic Health Plan must meet one of the following requirements:

1. Must be under the age of thirty (30); or
2. Must qualify for and have received a hardship exemption from the Health Insurance Marketplace.

Coverage is not effective until the Applicant is notified in writing by the Health Plan or the Marketplace of such date Coverage is to commence.

CHILD-ONLY POLICIES
An Individual who meets the eligibility requirements outlined above and who has not attained the age of twenty-one (21) at the beginning of the benefit year is eligible for a child-only policy. An Advanced Premium Tax Credit may be available to the parent/legal guardian who purchases coverage on behalf of a qualifying dependent child. In determining the parent’s/legal guardian’s premium tax credit eligibility, a qualifying dependent child is defined as:

1. A child of the taxpayer or descendent of such child or the brother, sister, stepbrother, or stepsister of the taxpayer or a descendent of any such relative; and

2. Has the same principal place of residence as the taxpayer for more than half of the year; and

3. Has not reached the age of nineteen (19) by the end of the Calendar Year, is a student who has not reached the age of twenty-four (24) by the end of the Calendar Year, or is permanently disabled; and

4. Has not provided over one-half of his or her own support for the Calendar Year; and

5. Has not filed a joint return with his or her Spouse.

As specified by the Affordable Care Act, the parent/legal guardian who claims the child on their tax return must provide that child with coverage.

ELIGIBILITY REQUIREMENTS FOR DEPENDENTS

Any individual who meets the eligibility criteria for Eligible Dependents is eligible to apply for Coverage under this Agreement as an Eligible Dependent only if the individual meets each of the following requirements:

1. Was named on the initial application for, or properly enrolled under, this Agreement.

2. Must not already be enrolled in a Medicare plan at the time of the application.

3. Must pay the applicable Premium.

In addition to the eligibility requirements listed above, dependents on a Catastrophic Health Plan must meet one of the following requirements:

1. Must be under the age of thirty (30); or

2. Must qualify for and have received a hardship exemption from the Health Insurance Marketplace.

An Eligible Dependent is considered one of the following:

1. The Policyholder’s Spouse under a legally valid existing marriage.

2. The Policyholder’s Domestic Partner. A Domestic Partner means an adult of the same or opposite sex whom the Policyholder is in a Domestic Partnership.
3. The Policyholder’s, Covered Spouse’s, or Covered Domestic Partner’s natural born, Newborn, Adopted, Foster, or step child (or a child for whom the Policyholder, Covered Spouse, or Covered Domestic Partner has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age twenty-six (26).

   a. 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 he or she meets the following requirements:
      i. The child is a Florida resident or a full or part-time student; and
      ii. The child is not provided coverage under any other group, blanket, franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

4. The 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. The Health Plan must be notified of a Newborn add-on within sixty (60) days of birth.

Note: It is the sole responsibility of the Policyholder to establish that a child meets the applicable eligibility requirements. Eligibility will terminate at the end of the Calendar Year in which the child no longer meets the eligibility criteria required to be an Eligible Dependent. The Health Plan reserves the right to periodically audit dependent eligibility status.

EXTENSION OF ELIGIBILITY FOR DEPENDENT CHILDREN WITH DISABILITIES

In the case of a dependent child with an intellectual or physical disability, such child is eligible to continue Coverage as a Covered Dependent, beyond the age of thirty (30), if the child:

1. Continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap, and

2. Is chiefly dependent upon the Policyholder or Policyholder’s Covered Spouse or Covered Domestic Partner for support and maintenance.

This eligibility shall terminate on the last day of the month in which the child does not meet the requirements for extended eligibility.

OTHER REQUIREMENTS/RULES REGARDING ELIGIBILITY

1. No individual whose Coverage with us has been terminated for cause or any other reason listed in the Disenrollment for Cause provision listed within this section shall be eligible to re-enroll with us.

2. No person shall be refused enrollment or re-enrollment with us because of race, color, creed, marital status, gender, or age (except as provided in the Eligibility Requirements for Policyholders and Dependents subsections above).

3. The Policyholder must notify us in writing as soon as possible when a Covered Dependent is no longer eligible for Coverage. In addition, any Policyholder who enrolled through the Marketplace is responsible for notifying the Marketplace of all change in circumstance.
events that would result in eligibility changes (for example, marriage, divorce, or birth of a Newborn). If a Covered Dependent fails to continue to meet each of the eligibility requirements under this Agreement, and such proper notification is not timely provided by the Policyholder to us (and to the Marketplace for Insureds enrolled in Marketplace plan, 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, upon notification from the Marketplace, 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 Policyholder provide proof, which is acceptable to us, of a Covered Dependent’s continued eligibility for Coverage.

B. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

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

GENERAL RULES FOR ENROLLMENT

1. All factual representations made by you to us in writing in connection with the issuance of this Agreement and enrollment hereunder must be accurate and complete. Any false, fraudulent or misleading information provided during the enrollment process, or at any other time, may result, in addition to any other legal right(s) we may have, in disqualification for, termination of, or rescission of Coverage.

2. We will not provide Coverage and benefits to any individual who would not have been entitled to enrollment with us had accurate and complete information been provided to us on a timely basis. In such cases, we may require you, or an individual legally responsible for you, to reimburse us for any payment we made on your behalf.

3. A qualified individual may enroll in this plan through the Health Insurance Marketplace at HealthCare.gov. The Marketplace follows enrollment rules specified by the Federal Government and the State of Florida. These enrollment rules may or may not apply if you enroll in this plan directly with us. If you enroll in this plan through the Marketplace, you may be eligible for tax credits to help pay for your cost of Coverage. The following sections discuss the rules and benefits of enrollment through the Marketplace.

4. Material Misrepresentations, omissions, concealment of facts and incorrect statements made by the Applicant, Policyholder or Covered Persons which are discovered by the Health Plan or the Marketplace may prevent payment of benefits under this Agreement and may void this Agreement for the individual making the misrepresentation, omission, concealment of facts or incorrect statement. Fraudulent misstatements discovered by the Health Plan, at any time, may result in this Agreement being voided or Claims being denied for the individual making or responsible for the fraudulent misstatement.

5. If, in applying for this Agreement or in enrolling yourself or dependents, you make a fraudulent statement or misrepresentation pertaining to, but not limited to, your geographical area, gender, age, or the gender and/or age of your dependents, our sole liability shall be the return of any unearned Premium, less benefit payments. However, at our discretion, we may elect to cancel the Agreement with forty-five (45) calendar days’ prior written notice or continue this Agreement provided that the Policyholder makes
payment to us for the full amount of the Premium which would have been in effect had you stated the true facts.

APPLYING FOR COVERAGE

To apply for Coverage under this Agreement through the Health Insurance Marketplace, you must:

1. Create a Marketplace account on HealthCare.gov.
2. Fill out and submit an online application or download and complete a paper application. You can also apply by phone or in-person with an assister.
3. Review and save the notice you receive that tells you what Coverage you are eligible for. You will receive this notice in the mail or in an email.
4. If you are eligible, shop for and enroll in the Health Plan’s Marketplace plan.
5. Send your first Premium payment to the Health Plan.

To apply for Coverage under this Agreement with the Health Plan outside the Marketplace, you must:

1. Complete and submit an application to us;
2. Provide information needed to determine eligibility, at our request;
3. Pay the required Premium; and
4. Complete and submit the required enrollment forms to add Eligible Dependents.

By submitting an application, you represent that you have permission from all of the people whose information is on the application to both submit their information to us or the Marketplace and receive any communications about their eligibility and enrollment.

EFFECTIVE DATE OF COVERAGE

Coverage shall become effective at 12:01 am Eastern Standard Time on the Insured’s Effective Date (shown on the Individual Plan Information Page of this Agreement).

ANNUAL OPEN ENROLLMENT PERIOD

The Open Enrollment Period is the period of time each year, determined by the Health Insurance Marketplace, when you can enroll in an Individual health insurance policy or change your coverage. Any changes made to your coverage during the Open Enrollment Period can be effective as early as January 1st. If you do not enroll or change coverage during the Open Enrollment Period, you must wait until the next Open Enrollment Period, unless you or your Eligible Dependents qualify for a Special Enrollment Period (SEP).

SPECIAL ENROLLMENT PERIODS
To enroll in Coverage under this Agreement or change your Coverage outside the annual Open Enrollment Period, you must qualify for a Special Enrollment Period (SEP). A SEP is a period of time, as designated by the Health Insurance Marketplace, immediately following a qualifying life event, during which you may apply for Coverage. The Effective Date of your new Coverage will depend on what type of qualifying life event occurred. Qualifying life events are established by state and federal law and include:

1. Gaining a dependent (e.g., marriage, birth of a Newborn child, Adoption or placement for Adoption or foster care);
2. Loss of minimum essential coverage (e.g., job loss, divorce, aging off a parent’s plan);
3. Moving your residence, gaining U.S. citizenship, or leaving incarceration.
4. For individuals already enrolled in a Marketplace plan: having a change in income or household status that affects eligibility for premium tax credits or cost-sharing reductions.

For more detailed information on what qualifies for a SEP and the length of the SEP, go to HealthCare.gov, or contact us.

**DEPENDENT ENROLLMENT**

An individual may be added upon becoming an Eligible Dependent of a Policyholder during a Special Enrollment Period.

**Newborn Child** – To enroll a Newborn child who is an Eligible Dependent, you must submit any enrollment forms we require to us. To add a Newborn through the Marketplace, contact the Marketplace and report the life change. We must be notified of all Newborn enrollments.

If we receive notice for enrollments from you or from the Marketplace within thirty-one (31) days of the 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.

If we receive notice 32-60 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. If notice of the birth is not given within sixty (60) days of birth, you will need to wait until the next annual Open Enrollment Period or for a Special Enrollment Period to add the Newborn.

**Note:** Coverage for a Newborn child of a Covered family member other than the Policyholder’s Spouse or Domestic Partner will automatically terminate eighteen (18) months after the birth of the Newborn child.

**Adopted Newborn Child** – To enroll an Adopted Newborn child who is an Eligible Dependent, you must submit any enrollment forms we require to us. To add an Adopted Newborn through the Marketplace, contact the Marketplace and report the life change. We must be notified of all Adopted Newborn enrollments.

Adopted Newborn Coverage shall take effect at the moment of birth provided the Health Plan is notified by the Covered Person to enroll the child within sixty (60) days of the Adopted Newborn’s date of birth. If the Covered Person enrolls the Adopted Newborn within thirty-one (31) days of the birth, no Premium will be charged for the first thirty-one (31) days of Coverage. If notice of the birth
is not given within sixty (60) days of birth, you will need to wait until the next annual Open Enrollment Period or for a Special Enrollment Period to add the Newborn.

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 Agreement. Proof of final Adoption must be submitted to us. It is your responsibility to notify us or the Marketplace 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 receipt of the written notice.

Adopted/Foster Children – To enroll an Adopted child (other than a Newborn) or Foster Child who is an Eligible Dependent, we must be notified, and you must submit any enrollment forms we require to us. To add an Adopted or Foster Child through the Marketplace, contact the Marketplace and report the life change.

Coverage shall be effective the date such Adopted or Foster Child is placed in the Policyholder’s residence, pursuant to Florida law, provided the Health Plan is notified by the Covered Person to enroll the child within sixty (60) days of the child’s placement. If the Covered Person enrolls the Adopted or Foster Child within thirty-one (31) days of the placement, Premium will not be charged for the child for the first thirty-one (31) days of Coverage. If the Adopted or Foster Child is enrolled within thirty-two (32) to sixty (60) days of the placement, Premium will be charged from the date of placement. If notice of the placement is not given within sixty (60) days of the child’s placement in the Policyholder’s residence, the Adopted or Foster Child will be 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. Proof of final Adoption must be submitted to us. It is your responsibility to notify us or the Marketplace 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. Additionally, if you enrolled in a Marketplace plan, it is your responsibility to notify the Marketplace 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.

Other Dependents – If other Eligible Dependents were not named on the application for this Agreement, 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 us or notify the Marketplace of a qualifying life event. 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.

Marital Status – You may apply for Coverage for an Eligible Dependent Spouse due to marriage. To apply for Coverage outside the Marketplace, the Policyholder must:

1. Complete and submit the enrollment forms required by us, and
2. Pay the applicable Premium.
To apply for Coverage under this Agreement through the Marketplace, the Policyholder must:

1. Contact the Marketplace and report the qualifying life event, and

2. Send the additional Premium payment to the Health Plan.

**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, the required enrollment forms for the Eligible Dependent must be received by us. To add an Eligible Dependent child through the Marketplace, contact the Marketplace and report the life event. If accepted, the Effective Date of Coverage for the Eligible Dependent will be determined by us or, in the case of Marketplace enrollment, by the Marketplace. You must pay the additional Premium for Coverage to be provided to the Eligible Dependent.

**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.

**C. RENEWAL CONDITIONS**

Coverage under this Agreement is for an initial benefit year and will automatically renew for successive benefit years, unless terminated as provided for in this Agreement. The benefit year for plans bought inside or outside the Marketplace begins January 1 of each year and ends December 31 of the same year. The benefit year ends December 31 even if the Insured’s Coverage started after January 1. Any changes to benefits or rates to a health insurance plan are made at the beginning of the Calendar Year. This plan is guaranteed renewable. However, the Health Plan may refuse to renew this Agreement and all Coverage provided for under this Agreement for any of the following reasons:

1. The Insured fails to timely pay Premium in accordance with the terms of the Agreement;

2. The Health Plan ceases offering this Agreement to all Insureds;

3. The Insured or Covered Dependent has performed a fraudulent act or practice or made an intentional misrepresentation of material fact under the terms of this Agreement;

4. The Policyholder no longer permanently resides in the Health Plan’s Service Area; or

5. The Health Plan elects to discontinue all Individual health Coverage in the State of Florida.

With the exception of non-payment of Premium or loss of eligibility, if the Health Plan decides to non-renew this Agreement for any of the reasons set forth above, the Health Plan will provide the Insured with at least forty-five (45) calendar days’ advance written notice. If the Health Plan ceases offering this Agreement to all Insureds, the Health Plan will provide the Insured ninety (90) calendar days’ written notice prior to renewal date and offer the option to purchase any other Individual Coverage currently being marketed by the Health Plan in the Service Area. If the Health Plan discontinues offering all Individual Coverage in Florida, the Health Plan will give all Insureds 180 calendar days’ written notice prior to the Agreement renewal date.
D. TERMINATION PROVISIONS

VOLUNTARY TERMINATION OF INSURED

An Insured may voluntarily terminate Coverage at any time. The Policyholder must submit their request for disenrollment, in writing, to the Health Plan. Such request must include the name and member ID number of each Covered Person who is to be dis-enrolled and the requested date of termination. Additionally, for Insureds who enrolled through the Health Insurance Marketplace, at least fourteen (14) days’ notice must be provided to the Marketplace.

While Coverage remains in force, the Insured shall be responsible for any Health Benefit Plan Premium after the Health Plan receives notification of disenrollment. Any Insured who elects to terminate Coverage will not be able to enroll in a new plan until the next annual Open Enrollment Period, unless the Insured qualifies for a Special Enrollment Period (SEP). Non-payment of Premium does not constitute voluntary termination.

INVOLUNTARY TERMINATION OF INSURED

Unless otherwise prohibited by law, if, in the Health Plan’s opinion, any of the following events occur, the Health Plan may terminate an Insured involuntarily. If an Insured’s Coverage is terminated by the Health Plan for any reason, other than for non-payment of Premium, the Health Plan will provide the Insured with at least forty-five (45) days’ advance written notice. The following outlines the circumstances that constitute involuntary termination:

1. Fraud, Including Misuse of the Insured’s ID Card

If any Insured willingly and knowingly permits the use of his/her or any other Insured’s Health Plan ID card by any other person, so uses another person’s card, or so uses an invalid card, then the misused card will be retained by the Health Plan as well as the Insured’s own ID card. If any Insured engages in fraudulent activity in the use of services, facilities, or Providers, or knowingly permits such fraud by another, the Health Plan may terminate the rights of the Insured or Insureds involved immediately upon written notification by the Health Plan to the Insured. If such activity does occur, the Health Plan reserves the rights to recoup any funds paid out under false pretenses or rescind the policy in its entirety.

2. Leaving the Service Area

Any Insured who leaves the Health Plan’s Service Area with the intent to relocate or establish a new residence outside of the Service Area, or any Insured who is absent from the Service Area for ninety (90) calendar days, is deemed to have left the Service Area and will no longer be eligible for Coverage under this Plan. Coverage will continue through the end of the month in which the Insured relocates or is deemed to have left the Service Area so long as the required Premium is paid.

For Covered Persons enrolled in a plan outside the Health Insurance Marketplace:
The Insured is required to notify the Health Plan in writing if the Insured leaves the Service Area for the purpose of relocation.

For Covered Persons enrolled in a Marketplace plan:
The Insured is required to contact the Marketplace to report a life change if the Insured leaves the Service Area for the purpose of relocation.
3. Non-Payment of Health Benefit Plan Premiums

If the Health Plan fails to receive the Policyholder’s Premium no later than the last day of the Grace Period, Coverage under this Health Benefit Plan will terminate as of the last day of the first month of the Grace Period. The Health Plan will provide the Policyholder with a notice of termination of Coverage that includes the reason for termination at least thirty (30) days prior to the last day of Coverage.

4. Disenrollment for Cause

If, in the Health Plan’s opinion, any of the following events occur, we may terminate an individual’s Coverage for cause:

   a. Fraud, intentional misrepresentation of material fact or omission in applying for Coverage of benefits;

   b. The knowing misrepresentation, omission or the giving of false information to us for the purpose of obtaining Coverage under this Agreement by you or on your behalf; or

   c. Misuse of the ID card.

TERMINATION DATE OF INSURED

A Policyholder’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. Policyholder’s have the right to Appeal the decision or find new coverage.

TERMINATION OF A COVERED DEPENDENT

A Covered Dependent’s Coverage will automatically terminate at midnight Eastern Standard Time on the date specified by the Health Plan for the following reasons:

1. The Policyholder’s Coverage terminates for any reason,

2. The Covered Dependent fails to continue to meet any of the applicable eligibility requirements,

3. Eighteen (18) months after the birth of a Newborn child who is the child of a Covered Dependent child,

4. The Covered Dependent’s Coverage is terminated by us for cause.

In the event the Policyholder wishes to delete a Covered Dependent from Coverage, the Policyholder must provide at least fourteen (14) days’ notice of the requested termination date. To request such termination, the required form must be forwarded to us. You may call Customer Service to obtain the required form from us. To terminate a Covered Dependent’s Coverage through the Marketplace, the Policyholder must contact the Marketplace to report a life change.
In the event the Policyholder wishes to terminate a Domestic Partner’s or Spouse’s Coverage (e.g., in the case of divorce), the required form must be submitted to us, prior to the required termination date or within ten (10) calendar days of the date the divorce is final, whichever is applicable. To terminate a Spouse’s or Domestic Partner’s Coverage through the Marketplace, contact the Marketplace to report a life change.

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

In addition to the provision stated in the Termination of a Covered Dependent subsection, the Covered Spouse’s and the Covered Spouse’s Covered Dependent child’s Coverage under the Agreement will terminate at midnight on the date that the marriage terminates or the date of death of the Spouse. The Covered Domestic Partner’s and the Covered Domestic Partner’s Covered Dependent child’s Coverage under the Agreement will terminate at midnight on the date that the Domestic Partnership ends or the date of death of the Domestic Partner.

The Policyholder must provide notification within ten (10) calendar days of when the Spouse’s or Domestic Partner’s eligibility requirements are no longer met or within ten (10) calendar days of the death of the Covered Spouse or Covered Domestic Partner.

For Covered Persons enrolled in a plan outside the Health Insurance Marketplace:
The Policyholder must notify the Health Plan, in writing, of the death of the Covered Spouse or Covered Domestic Partner or when the Spouse or Domestic Partner ceases to meet applicable eligibility requirements.

For Covered Persons enrolled in a Marketplace plan:
The Policyholder must notify the Marketplace of the death of the Covered Spouse or Covered Domestic Partner or when the Spouse or Domestic Partner ceases to meet applicable eligibility requirements.

**POLICYHOLDER’S RESPONSIBILITY FOR NOTIFYING US OF INELIGIBILITY OF COVERED DEPENDENTS**

The Policyholder must notify us in writing immediately if any Covered Dependent ceases to meet all of the applicable eligibility requirements specified in the Eligibility section of this Agreement, but no later than thirty-one (31) calendar days after the Covered Dependent ceases to be eligible for Coverage. If notification of the change is received after the 31-day period from the date the Covered Dependent ceases to be eligible, the change will be made effective as of a current date and no Premiums will be refunded. See also “Continuing Coverage on Termination of Eligibility” below.

**CONTINUING COVERAGE ON TERMINATION OF ELIGIBILITY**

If Coverage ceases because of termination of eligibility under this Agreement, you shall be entitled to be issued a Policy in your name without evidence of insurability, provided that application is made and Premiums are paid within thirty-one (31) calendar days after termination. There will be continuous Coverage during the 31-day period, if such Coverage is selected and the Premiums are paid. See also “Policyholder’s Responsibility for Notice of Ineligibility of Covered Dependents” above.

**TIME LIMIT FOR CERTAIN DEFENSES**
After two (2) years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny and claim for loss incurred or disability starting after the two-year period.

E. CERTIFICATE OF CREDITABLE COVERAGE

Within thirty-one (31) calendar days of a Policyholder’s or Covered Dependent’s last date of Coverage under the Health Plan, a Certificate of Creditable Coverage will be produced and mailed to the Policyholder’s last known address on file. This Certificate will indicate who was Covered under the Health Plan and the period of time the Policyholder or Covered Dependent was enrolled under the Health Plan. The Certificate of Creditable Coverage provides evidence of a Policyholder’s or Covered Dependent’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 toll free at (844) 522-5279 for assistance.

F. RESCISSION OF COVERAGE

We reserve the right to rescind the Coverage under this Agreement as permitted by law. The Health Plan can only rescind the Agreement or Coverage of an individual Covered under the Agreement 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 Appeal procedure described in the Complaint, Grievance & Appeal Procedures section of this Agreement.

G. PREMIUM PAYMENTS

Premiums are required to be paid in order for this Agreement to be effective. Premiums are billed on a monthly basis and must be paid in accordance with established time frames to maintain eligibility. The time frames are included with the billing statement. Premiums are established for the type of Health Benefit Plan. Subject to the approval of the Office of Insurance Regulation, the Health Plan reserves the right to adjust the Premium charged to a Policyholder, upon the Policyholder’s renewal date, with no less than forty-five (45) calendar days’ notice to the Policyholder. All Premium adjustments will be deemed accepted by the Policyholder unless a request for termination is received any time prior to the Effective Date of the adjustment. If such notice requesting termination is received from the Policyholder, this Agreement will terminate on the date the adjustment would have been effective. The Policyholder must submit their request for disenrollment, in writing, to the Health Plan. Additionally, for Insureds who enrolled through the Health Insurance Marketplace, notice must be provided to the Marketplace.

H. GRACE PERIOD

Qualified individuals receiving an Advanced Premium Tax Credit (APTC) through the Health Insurance Marketplace have a Grace Period of three (3) consecutive months if the Insured has previously paid at least one (1) full month’s Premium during the benefit year. All other Insureds have a thirty (30) calendar day Grace Period if the Insured has previously paid at least one (1) full month’s Premium during the benefit year. This provision means that if any required Premium is not
paid on or before the date it is due, it must be paid and received by the Health Plan during this Grace Period. During the Grace Period, Coverage under this Agreement will stay in force. In no event will termination relieve the Policyholder of his/her obligation under this Agreement to pay us any prorated portion of the Premium applicable to the period of time during which we have provided benefits, or for any amounts otherwise due to us. The Insured will receive written notice of termination due to nonpayment of Premium prior to the end of the Grace Period.

For an Insured receiving an APTC and who is within the three (3) month Grace Period, the Health Plan may pend Claims for services rendered during the second and third months of the Grace Period. If the Insured fails to pay the Premium before the end of the Grace Period, the Health Plan may then deny any Claims that were pended during the second and third months of the Grace Period.

I. REAPPLICATION

For Insureds enrolled in an Individual Policy outside the Health Insurance Marketplace:

Any payment received after the Grace Period will be considered a reapplication for Coverage and will be subject to the regular policies and procedures of the Health Plan for evaluating Coverage. Reenrollment will be at the discretion of the Health Plan. Within five (5) business days of termination, we will send you a termination notice and Reapplication form. To re-apply for Coverage, you must return the Reapplication form with any outstanding Premiums within thirty (30) calendar days of receipt of the termination notice. The reapplication process will not begin until the Health Plan receives all back Premiums in the correct amount.

The completion of the Reapplication form does not guarantee re-enrollment even though payment has been submitted and received. If the Health Plan approves your reapplication, you will be re-enrolled and Coverage will continue from this Agreement's Coverage Effective Date. No Premiums will be applied to any period more than sixty (60) days before the reinstatement date. Any Premium paid in connection with this application will be returned if this Agreement is not re-issued. If the Reapplication form is not received within thirty (30) calendar days from the date of notification of termination, you must contact the Health Plan to apply for a new Agreement.

For Insureds enrolled in a Marketplace plan:

An Insured enrolled in a Marketplace plan who is notified that their enrollment has been terminated by the Health Plan for non-payment of Premium must make a new plan selection by creating a new Marketplace account and completing a new Marketplace application. The Effective Date of Coverage will be based on the date of the new plan selection under the Marketplace Effective Date schedule.

J. DISCRETIONARY AUTHORITY

The Health Plan, in accordance with the Affordable Care Act, has the discretionary authority to determine eligibility, to construe terms of this Agreement, and to make decisions concerning Claims for benefits under the terms of this Agreement.

K. CONFORMITY WITH STATE STATUTES
Any provision of this policy 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.

III. COVERAGE PROVISIONS

This section provides important information about the Coverage of Health Care Services provided under this Individual Policy, explaining:

1. Guidelines the Policyholder and Covered Dependent(s) must follow in accessing care,
2. The services and supplies that are Covered, and
3. The services and supplies that are excluded from Coverage.

It is important to remember that exclusions and limitations also apply to your Coverage. Exclusions and limitations that are specific to a type of service or supply are included along with the benefit description in the Covered Services section. Additional exclusions and limitations that may apply can be found within the Exclusions and Limitations section. More than one limitation or exclusion may apply to a specific service or a particular situation.

Expenses for the Health Care Services listed in the Covered Services section will be Covered under this Agreement only if the services are:

1. Within the Covered Services categories in the Covered Services section of this agreement;
2. Actually rendered to you (not just proposed or recommended) by an appropriately licensed health care Provider who is recognized for payment by us and for which we receive an itemized statement or description of the procedure or service which was rendered, including any applicable procedure code, diagnosis code and other information we require in order to process a claim for service;
3. Medically Necessary, as defined in this Agreement by us in accordance with our Medical Necessity coverage criteria then in effect, except as specified in this section;
4. In accordance with our benefit guidelines listed in the Covered Services section;
5. Rendered while your Coverage is in force; and
6. Not specifically or general limited or excluded under this Agreement.

We will determine whether services are Covered Services under this Agreement after you have obtained the services and we have received a Claim for the services. In some circumstances, we may determine whether services might be Covered Services under this Agreement before such services are rendered. For example, we may determine whether a proposed surgery would be a Covered Service under this Agreement before the surgery is provided. We are not obligated to determine, in advance, whether any service not yet provided to you would be a Covered Service unless we have specifically designated that a service is subject to a Prior Authorization requirement as described in the Prior Authorization subsection. We are also not obligated to Cover or pay for any service that has not actually been rendered to you.
In determining whether Health Care Services are Covered Services under this Agreement, no written or verbal representation by an employee or agent of the Health Plan or by any other person shall waive or otherwise modify the terms of this Agreement; therefore, neither you, nor any health care Provider or other person should rely on any such written or verbal representation.

For information on Prescription Drug Coverage, please refer to the Health Plan Pharmacy Program section of this Agreement.

**COVERAGE ACCESS GUIDELINES**

It is important that Policyholders 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, the Primary Care Physician, and what to do if Emergency Services or Care are needed.

**A. CHOOSING A PRIMARY CARE PHYSICIAN**

Under your Individual Policy, 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.

Insureds are free to choose any PCP from the published list of Primary Care Physicians whose practices are open to new patients. Each female Insured may select as her PCP an Obstetrician/Gynecologist (OB/GYN) who has agreed to serve as a PCP and is in the Health Plan’s Provider Network. Please note: The OB/GYN acting as a PCP must agree to be reimbursed at a PCP rate. 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. ADDITIONAL HEALTH CARE PROVIDER INFORMATION**

If a Participating Provider terminates his or her Agreement with the Health Plan or is terminated by the Health Plan for any reason other than for cause, a Policyholder or Covered Dependent 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 agreed reimbursement rate) when Medically Necessary and through completion of treatment of a Condition for which the Policyholder or Covered Dependent was receiving care at the time of the termination. Access to such terminated Provider may continue through the current period of active treatment or for up to
ninety (90) calendar days, whichever is less, for members undergoing treatment for a chronic or acute medical Condition.

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

A Policyholder or Covered Dependent 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.

C. ACCESSING SPECIALTY CARE

The Health Plan does not require Policyholders or Covered Dependents to obtain a referral from the Primary Care Physician prior to seeking services from a participating Specialist. However, certain participating Specialists will not accept appointments directly from Policyholders or Covered Dependents that have not been “referred” for care. In these instances, Policyholders and Covered Dependents will first need to see a Primary Care Physician.

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

D. PRIOR AUTHORIZATION

In order for certain services to be Covered, prior approval by the Health Plan is required. This provision includes Inpatient care and certain diagnostic and medical procedures (except for Emergency Medical Conditions or Urgent Care) and pharmaceutical services. If services requiring Prior Authorization are obtained without proper authorization, the Policyholder or Covered Dependent may be responsible for their entire cost. Services requiring Prior Authorization are subject to change. A current list of services requiring Prior Authorization is available through the Health Plan’s Customer Service Department and posted on the Health Plan’s public website at 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 Physician requesting the authorization will be considered an authorized representative of the Policyholder or Covered Dependent during the prior authorization process. All related communications will be directed from the Health Plan to the requesting Physician, who will communicate with the Policyholder or Covered Dependent. If authorization is denied for any reason, both the Policyholder or Covered Dependent and the requesting Physician 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) policy who utilize their Out-of-Network benefits for non-Emergency or 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 physician will be notified within seventy-two (72) hours. If additional information is required in order to make a decision, the information will be requested...
from the physician within twenty-four (24) hours of the Prior Authorization request. The Physician will have forty-eight (48) hours from the time requested to provide the additional information. A decision will be made and the Physician will be notified within forty-eight (48) hours after the earlier of (a) the receipt of requested information or (b) the end of the period afforded to submit the information.

**STANDARD PRE-SERVICE AUTHORIZATIONS**

A decision will be made and the requesting Physician will be notified within fifteen (15) calendar days. If an extension is necessary due to circumstances beyond the Health Plan’s control, a fifteen (15) calendar day extension may be applied, for a total of thirty (30) 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 Physician within fifteen (15) calendar days of the Prior Authorization request. The Physician will have forty-five (45) calendar days within which to provide the requested information. A decision will be made and the Physician will be notified within fifteen (15) calendar days after the earlier of (a) the receipt of requested information or (b) the end of the period afforded to submit the information.

**E. EMERGENCY AND URGENT CARE SERVICES**

**EMERGENCY SERVICES AND CARE**

In the event of an Emergency Medical Condition, the Policyholder or Covered Dependent 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 specialty 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. All follow-up care must be coordinated and authorized 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 a Health Maintenance Organization (HMO) policy 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 Insureds, Coverage outside the Service Area is 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 Coverage are listed in the Schedule of Benefits attached to this Agreement.

**F. MEDICAL PAYMENT GUIDELINES FOR NON-PARTICIPATING PROVIDER CARE**

If the Policyholder or Covered Dependent requires care from a Non-Participating Provider, and such care has been authorized in advance when required by the Health Plan, 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 the Policyholder or Covered Dependent 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 Policyholder or Covered Dependent 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 In-Network 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.

All services and supplies received by a HMO member must be rendered by In-Network Providers in order to be Covered (except in the case of Emergency Services or Urgent Care). This is true even when the services or supplies received are Medically Necessary. However, if a Covered Person requires care that is not available within the Health Plan’s Provider Network, arrangements will be made by the Health Plan to provide the appropriate care elsewhere. In these instances, and when the proper Prior Authorization is obtained from the Health Plan, both HMO and POS members shall be responsible for the appropriate In-Network Cost-Share.

G. THE CALENDAR YEAR DEDUCTIBLE

A Deductible is a specific annual dollar amount that is payable by the Covered Person for Covered benefits received each Calendar Year. This amount, when applicable, must be satisfied by the Covered Person each Calendar Year before any benefits subject to the Deductible are payable by the Health Plan. 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. Certain Covered Services that are subject to a Copayment are not subject to the Calendar Year Deductible. Covered Services that are subject to the Calendar Year Deductible under this Individual Policy 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 and Prescription Drugs not Covered by this Agreement,

2. Any charges in excess of the Allowed Amount, and

3. Expenses that relate to services that exceed specific treatment limitations explained in this section or noted in the Schedule of Benefits.

Covered Prescription Drugs may also be subject to a Calendar Year Deductible. Some plans include a separate Deductible for Covered Prescription Drugs, while others include a single Deductible that both Covered medical services and Prescription Drug expenses contribute to. The Prescription Drug Coverage under this Individual Policy is shown in the Schedule of Benefits.

For more information about the Calendar Year Deductible, refer to the “Understanding Your Share of Health Care Expenses” section of this Agreement.

H. COPAYMENTS (IF APPLICABLE)
For some Covered Services, the Policyholder or Covered Dependent is responsible for paying a flat dollar amount for Covered Services. This dollar amount is referred to as a Copayment. Copayments are due at the time of service. Certain Covered Services and Prescription Drugs may be subject to the Calendar Year Deductible prior to the Copayment applying. The Copayment requirements for this Agreement are set forth in the Schedule of Benefits and will apply in full, regardless of the amount of the actual charges.

For more information about the Copayment requirements, refer to the “Understanding Your Share of Health Care Expenses” section of this Agreement.

I. THE COINSURANCE PERCENTAGE

After satisfaction of the Calendar Year Deductible, the Policyholder or Covered Dependent may be responsible for paying a percentage of the Allowed Amount for Covered Services. This percentage that the Policyholder or Covered Dependent is responsible for is called the Coinsurance Percentage. The Coinsurance Percentage for this Individual Policy is shown in the Schedule of Benefits.

When charges are incurred for Covered Services or supplies provided by Participating Providers, this Individual Policy 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.

J. 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 must be paid in a Calendar Year by a Covered Person before this Agreement pays Covered Services and Covered Prescription Drugs at one hundred percent (100%) of the Allowance determination for the remainder of that Calendar Year. All Covered Person’s Cost-Sharing for Covered Services and Covered Prescription Drugs, including any applicable Calendar Year Deductible, Copayments and Coinsurance, contribute toward the Out-of-Pocket Maximum Expense Limit.

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 Agreement,

2. Any charges in excess of the Allowed Amount, or

3. Expenses that relate to services that exceed specific treatment limitations explained in the Covered Services section of this Agreement or noted in the Schedule of Benefits.

For more information about the Calendar Year Out-of-Pocket Maximum Expense Limit, refer to the “Understanding Your Share of Health Care Expenses” section of this Agreement.

K. INDIVIDUAL PLAN REPLACEMENT
The prior health insurance plan may be required to provide certain benefits to certain Insured under an extension of benefits provision. In no event under this Individual Policy Agreement shall the Health Plan pay any Claims for services or supplies that are covered under any provision in the prior health plan relating to extension of benefits, until the extension of benefits for the Condition under the prior plan ends for the Insured, when applicable.

IV. COVERED SERVICES

This section describes the services that are Covered under this Individual Policy and those that are not Covered. It is important that this whole section 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 attached to this Agreement.

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

COVERED SERVICES CATEGORIES

The services and supplies listed below will be considered Covered Services under this Individual Policy 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 Agreement for more information);

3. Received from or provided under the orders, direction or referral from a Participating Provider as published in the Provider Directory, except for Urgent or Emergency Services and Care, unless the Covered Person is enrolled in a Point-of-Service (POS) policy and is utilizing his/her Out-of-Network benefit;

4. Actually rendered while Coverage under this Agreement is in force;

5. Medically Necessary, as defined in this Agreement; and

6. Not specifically limited or excluded under this Agreement.

Insureds 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 Allowed Amount. (See the Definitions section of this Agreement.)

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 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. Please refer to your Schedule of Benefits for the per-day maximums for Ambulance services.

**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.

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 eighteen (18) 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
For Covered Persons nineteen (19) years of age or older, Covered dental services are limited to the following:

1. Care and stabilization treatment rendered within sixty-two (62) calendar days of an Accidental Dental Injury, provided such services are for the treatment of damage to Sound Natural Teeth.
2. Extractions of teeth to prepare the jaw for required radiation treatment of neoplastic disease, and for an oral or dental examination performed on an inpatient basis as part of a comprehensive workup prior to renal transplant surgery, or prior to a heart valve replacement.
3. Anesthesia services for dental care, including general anesthesia and hospitalization services, necessary to assure the safe delivery of necessary dental care provided to you in a Hospital or Ambulatory Surgical Center if you have one or more medical Conditions that would create significant or undue medical risk for you in the course of delivery of any necessary dental treatment or surgery if not rendered in Hospital or Ambulatory Surgical Center.

The above Covered Services are separate from the Pediatric Dental benefit described in the Pediatric Dental attachment to this policy.

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 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 the 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 Individual Policy. The specified Durable Medical Equipment will not, in whole or in part, serve as a comfort or convenience item for the Policyholder or Covered Dependent or be available over-the-counter. Supplies and service to repair medical equipment may be a Covered benefit only if the Policyholder 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 Policyholder'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 Insureds 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).

**Fitness Center Membership**
Fitness center membership is Covered to assist all Insureds with maintaining or improving their health status. The Health Plan offers a fitness center membership to Policyholders 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 Chromosomai 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 Agreement); 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. Sixty (60) visits maximum per Calendar Year as outlined 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. Policyholders 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 Policyholder 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, include care for pain control or acute chronic symptom management.

The Hospice treatment program must:

1. Meet the standards outlined by the National Hospice Association; and
2. Be recognized as an approved Hospice program; and
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. 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 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 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.

Coverage is limited as shown in the Schedule of Benefits.

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. See the Formulary for information about Coverage of weight-loss Drugs.

Obstetrical and Maternity Care
Obstetrical and maternity care received on an Inpatient or outpatient basis are Covered, including Medically Necessary prenatal and postnatal care of the mother and baby. Up to fifteen (15) prenatal and postnatal office visits per 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). 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,
4. Individuals who have primary hyperparathyroidism and individuals who have a family history of osteoporosis.
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 Policyholder'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.

Pediatric Dental Services
Pediatric dental services are Covered only if they are:

1. Rendered to a Covered Person who has not reached the age of nineteen (19);
2. Rendered by the primary care dentist assigned or a dentist that has been referred to by the primary care dentist;
3. Not specifically or generally limited or excluded as outlined in the dental attachment; and
4. Authorized for Coverage as outlined in the dental attachment if prior coverage authorization is required.

Please see the attached Pediatric Dental policy for Coverage, Limitations and Prior Authorization requirements.

Pediatric Vision Services
The following pediatric vision services are Covered for Insureds under age nineteen (19) when provided by a Participating Provider:

1. One (1) routine vision exam per Calendar Year, and
2. One (1) pair of standard child frame and basic lenses per Calendar Year. Eligible Prescription lenses include single vision, bifocal and trifocal lenses.

Pediatric vision services or materials that are not furnished by a Participating ophthalmologist, optometrist or optician are not Covered.

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 Dependent 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. All other plan requirements, including Medical Necessity, must also be met for the Prescription Drugs to be a Covered benefit.

**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 and Habilitative Services**

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, or to help a person keep, learn, or improve skills and functioning for daily living. 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.
2. Occupational Therapy (OT) provided by a physician or licensed occupational therapist.
3. Speech Therapy (ST) provided by a physician or licensed speech therapist.
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 (36) sessions per lifetime.

**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 Prior 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. Insureds may be responsible for charges in excess of this amount. Insureds Covered under a HMO policy 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 policy, 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 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.

8. 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
Coverage of self-administered Prescription Drugs 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 are limited to sixty (60) 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 retirement 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 Agreement.

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, is Covered when Medically Necessary and authorized in advance when Prior Authorization is required.

Smoking Cessation Programs
Smoking cessation programs, including services or 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-six (26) 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 agreement, 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 through 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 Individual Policy 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 and donor costs and Bone Marrow Transplants as specifically outlined in this Agreement. However, donor costs are not payable under this Individual Policy 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.

The above Covered Services are separate from the Pediatric Vision benefit described in the Pediatric Vision Services category.

**Well Woman Annual Exam**
An annual well woman gynecological exam is Covered at an obstetrician/gynecologist 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 & LIMITATIONS**

**A. ACCESS RULES**

If Policyholders and their Covered Dependents do not follow the access rules described in this section, the Policyholder and their Covered Dependents risk having services and supplies received not Covered by this Individual Policy. In such a circumstance, the Policyholder or Covered Dependent 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 the Insured is Covered under a Point-of-Service (POS) policy.

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 Medically Necessary or a Covered Service.

B. HEALTH 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 Individual Policy.

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 are excluded from Coverage. Examples of alternative medical treatments include:

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 Agreement 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 is excluded from Coverage. Examples of assisted reproductive therapy include 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.

**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**
Charges, expenses or costs in excess of the Health Plan's Allowed Amount for Covered Services 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 a 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 Agreement), including, without limitation, 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 Insured 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**

All dental procedures, other than those described in the Covered Services section of this Agreement, are excluded from Coverage. This exclusion includes the following: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, dental implants, periodontal or endodontic procedures, orthodontic treatment, including palatal expansion devices, bruxism appliances and dental x-rays. 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. Additionally, dental services provided more than sixty-two (62) days after the date of an Accidental Dental Injury, regardless of whether or not the services could have been rendered within sixty-two (62) days, are excluded from Coverage.

This exclusion does not apply to dental services Covered under the Dental Services, Child Cleft Lip and Cleft Palate Treatment, and Pediatric Dental Services categories of the Covered Services section of this Agreement.

**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 Agreement for Covered Durable Medical Equipment items.

**Experimental and Investigational Treatment**

Experimental and Investigational Treatment, as defined in the Definitions section of this Agreement, are 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 Agreement.

**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 Agreement.

**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 routine 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 Agreement.

**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.

**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 Policyholder or Covered Dependent been confined in a Hospital are also excluded from Coverage.
**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 Agreement 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.

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

**Immunizations and Physical Examinations**
Immunization 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 services and supplies, including infertility testing, treatment of infertility and diagnostic procedures to determine or correct the cause or reason for infertility or inability to achieve conception, are excluded from Coverage. This exclusion includes the medication 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 on the plan’s Formulary.

**Learning and Developmental Services**
Testing, therapy or treatment for reading and learning disabilities are not Covered. Services or treatment for mental retardation or other mental services are not Covered unless determined to be Medically Necessary.

**Massage Therapy**
Massage therapy is not Covered under this Health Plan.
Mental Health Services and Supplies
The following mental health services are excluded from Coverage:

1. Services 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 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 disabilities or for mental retardation;
4. Services for marriage 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.

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 Covered Person is legally entitled to receive from military or government facilities when such facilities are reasonably accessible to the Covered Person 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. This includes 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-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 Agreement, 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 a Policyholder or Covered Dependent has received, or is expecting to receive, any benefit under Workers’ Compensation, Occupational Disease Law or similar law are excluded from Coverage. If the Policyholder or Covered Dependent 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 Policyholder or Covered Dependent is Covered by a Workers’ Compensation program that limits benefits if other than specified Health Care Providers are used, and the Policyholder or Covered Dependent receives care or services from a Health Care Provider not specified by the program, this 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 under the Covered Services section of this Agreement.

Organ Donor Treatment or 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 Agreement.

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 obtained without a Prescription are excluded from Coverage. Examples of 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 your treatment are excluded from Coverage. Examples of
personal comfort, hygiene or convenience items and services include:

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

**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 Agreement.

**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, unless such services are specifically required to be Covered by federal law.
4. Court ordered care or treatment, unless otherwise Covered under this Individual Policy.
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 Individual Policy, unless Coverage is extended in accordance with the Extension of Benefits provision in the Administrative Provisions section of this Agreement.
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. This exclusion includes any service or supply related to such treatment, including psychiatric services.

**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.

**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 Agreement, 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 are excluded from Coverage. Examples of training and educational programs and materials include materials for Pain Management, vision training or vocational rehabilitation, except as provided under the Diabetes Outpatient Self-Management and Maternity categories of the Covered Services section of this Agreement.

**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 Agreement, 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 Policyholder or Covered Dependent.
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 Agreement.

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

Vision Services
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 and Pediatric Vision Services categories of the Covered Services section of this Agreement.

Volunteer Services
Volunteer services, or services which 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 the extent the Covered Service is paid by Workers’ Compensation through adjudication or settlement, 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 Agreement, 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 Agreement 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 Agreement; 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) INSUREDS UTILIZING OUT-OF-NETWORK PROVIDERS

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 Agreement.

2. 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. DEDUCTIBLE REQUIREMENTS

This Individual Policy has both an individual Calendar Year Deductible and a family Calendar Year Deductible. However, a family Deductible only applies if you have family Coverage (i.e. Coverage for a Policyholder and one or more Covered Dependents under this Agreement).

INDIVIDUAL CALENDAR YEAR DEDUCTIBLE

This amount, when applicable, must be satisfied by you and each of your Covered Dependents each Calendar Year before any payment will be made by us for benefits subject to the Deductible. 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. 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 applicable Allowed Amount.

FAMILY CALENDAR YEAR DEDUCTIBLE

If you have family Coverage (i.e. Coverage for a Policyholder and one or more Covered Dependents under this Agreement), your plan includes a family Calendar Year Deductible. If you are an Insured 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 applicable.
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.

Please see your Schedule of Benefits for more information about this Individual Policy's Deductibles.

B. COPAYMENT REQUIREMENTS

Covered Services rendered by certain Providers or at certain locations or settings may be subject to a Copayment requirement. This is the dollar amount you have to pay when you receive these services. Please refer to your Schedule of Benefits for the specific Covered Services that are subject to a Copayment. Listed below is a brief description of some of the Copayment requirements that may apply to your Agreement.

In some cases, when our Allowed Amount or the Provider's actual charge for a Covered Service rendered is less than the Copayment amount, you may be responsible for the lesser of our Allowed Amount or the Provider's actual charge for the Covered Service.

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 Agreement, 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. The Copayment for Inpatient Facility services, if applicable to your Agreement, applies, regardless of the reason for the admission, and applies to all Inpatient admissions to a Hospital or Psychiatric Facility within or outside the Service Area.

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 Agreement, 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 Agreement, 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 Agreement, must be satisfied by you for each visit. 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 Agreement, 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. COINSURANCE REQUIREMENTS

After satisfaction of the Calendar Year Deductible, the Policyholder or Covered Dependent may be responsible for paying a percentage of the Allowed Amount for Covered Services. This percentage that the Policyholder or Covered Dependent is responsible for is called the Coinsurance Percentage. For services that are subject to Coinsurance, the Coinsurance percentage of the applicable Allowed Amount you are responsible for is listed in your Schedule of Benefits.

D. OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum Expense Limit is the maximum amount of expenses that must be paid in a Calendar Year by a Policyholder or Covered Dependent before this Agreement pays Covered Services and Covered Prescription Drugs at 100% of the Allowance determination for the remainder of that Calendar Year, as set forth in the Schedule of Benefits. All Covered Person’s Cost-Sharing for Covered Services and Covered Prescription Drugs, including any applicable Calendar Year Deductible, Copayments and Coinsurance, contribute toward the Out-of-Pocket Maximum Expense Limit.

This Individual Policy has both an individual Out-of-Pocket Maximum Expense Limit and a family Out-of-Pocket Maximum Expense Limit. However, a family Out-of-Pocket Maximum Expense Limit only applies if you have family Coverage (i.e. Coverage for a Policyholder and one or more Covered Dependents under this Agreement).

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 one hundred (100) percent of the Allowed Amount for Covered Services rendered during the remainder of that Calendar Year.

FAMILY OUT-OF-POCKET CALENDAR YEAR MAXIMUM

If you are an Insured with a family Out-of-Pocket Maximum Expense Limit, your Out-of-Pocket Maximum Expense Limit 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 meet 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, if applicable, is the amount applied toward the individual Out-of-Pocket Calendar Year Maximum. Please see your Schedule of Benefits for more information.

**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.

**E. ADDITIONAL EXPENSES YOU MUST PAY**

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

1. The Premium applicable to your Agreement;

2. Expenses incurred for non-Covered Services;

3. Charges in excess of any maximum benefit limitation listed in this Agreement or your Schedule of Benefits;

4. 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;

5. Any benefit reductions; and

6. Charges for Health Care Services which are excluded.

**VII. CLAIM PROVISIONS**

A Claim is any request for a Plan benefit or benefits made in accordance with these 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 services to be received from Participating Providers through a contractual arrangement. If a Policyholder or Covered Dependent receives 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 Policyholder or Covered Dependent 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 Policyholder or Covered Dependent 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.

Notwithstanding the provisions in this section, the Health Plan is entitled to reimbursement from the subscriber in accordance with Section 641.31(8) F.S. or the decision of a court of competent jurisdiction.

The following provisions apply in the event the Policyholder or Covered Dependent 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 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 Claim for Benefits form will be treated as received by the 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:**

Health First Health Plans - FHCA  
ATTN: Benefits Reimbursement Unit  
P.O. Box 69355  
Harrisburg, PA 17106-9355

**Reimbursement requests for Prescription Drugs must be sent to:**

Health First Health Plans - FHCA  
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 Covered Person. However, if a participant believes the Pharmacy has applied the wrong Cost-Sharing amounts, the Covered Person may pay the amount as 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 a Covered Person will make payment, other than their required Cost-Share, for any benefits provided hereunder. However, if such payments are made, the Covered Person shall submit a timely Claim for reimbursement to the Health Plan. In order for a Claim for reimbursement to be considered, the Covered Person 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 section C 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 from a Covered Person 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 Covered Person 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 Covered Person, 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 Plans shall pay or deny all Claims no later than 120 days after receiving the Claim for electronic Claims and 140 days after receiving paper Claims.

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 a Covered Person, 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 Covered Person was properly billed for only those procedures and services that the Covered Person actually received. If the Health Plan determines that the Covered Person has been improperly billed, the Health Plan shall notify the Covered Person 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 Covered Person, 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 Agreement, 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 one hundred (100) percent of the total allowed expenses actually incurred.

PLANS AFFECTED

If any of the other health coverage plan(s) a Covered Person has covers at least a portion of Health Care Services or supplies Covered under this Health 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 agreements, 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 Covered Person has will be considered separately with respect to that portion of any such policy, agreement, 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 the total benefits under all your plans will not exceed 100 percent 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 Covered Person 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 of benefit payments, the following guidelines will be used:

1. The benefits of a Plan that covers the Insured other than as a Covered Dependent are determined before the benefits of the Plan(s) that covers the Insured as a Covered Dependent.

2. The parents' birth dates. Except for cases where the Covered Dependent child's parents are separated or divorced, 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 Covered 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 Covered Dependent of the parent with custody of the child will be determined before the benefits of the plan which cover the child as a Covered 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 Covered Dependent...
Dependent of the parent with custody shall be determined before the benefits of a plan which cover that child as a Covered Dependent of the step-parent; and the benefits of a plan which cover that child as a Covered Dependent of a step-parent will be determined before the benefits of a plan which covers the child as a Covered 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 Covered Dependent of the parent with such financial responsibility shall be determined before the benefits of any other program which cover the child as a Covered 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 Policyholder or Covered Dependent under this Health 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 Health Plan.

F. THIRD PARTY LIABILITY AND RIGHT OF RECOVERY

An Insured 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 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 Policyholder 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 Policyholder’s or Covered Dependent’s right to receive payments from the Other Party. The Policyholder or Covered Dependent 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 Health Plan on behalf of the Policyholder or Covered Dependent; and/or

2. Recover from the Policyholder or Covered Dependent any benefits paid under the Health Plan on the Policyholder’s or Covered Dependent’s behalf out of the recovery made from the Other Party (whether by lawsuit, settlement, or otherwise).

The Insured must cooperate fully with the Health Plan in regards to subrogation and recovery rights. The Insured 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 subrogation and recovery rights are not contingent upon the receipt of such documents. The Insured 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 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 Health 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 agrees 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 agrees 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 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 will be liable to the Health Plan for the amount of the benefits paid under the Health Plan;

2. The Insured 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 by the Health Plan for any illness, Sickness or bodily Injury, up to the amount of the payment that the Insured has received from the Other Party; and

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

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

G. RIGHT TO RECEIVE AND RELEASE INFORMATION

The Health Plan has the right to receive and release necessary information to administer this Policy. By accepting Coverage under this Individual Policy, the Insured gives permission for the Health Plan to obtain from or release to any insurance company or 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 Health Plan agrees to furnish 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 Agreement, 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 Individual Policy shall not duplicate any benefits that are received or paid to the Insured under governmental programs, such as, but not limited to, Medicare, Veterans Administration, TRI-CARE (CHAMPUS), or any Workers’ Compensation Act, to the extent allowed by law. In any event, if this Individual Policy 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 an Insured 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 Insured enters into a settlement giving up rights to recover past or future medical benefits under Workers’ Compensation law, this Health Plan will not Cover past or future medical services that are the 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.

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 Agreement. 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 sixty (60) days from 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 Individual Policy until at least sixty (60) days after written Claim and supporting documentation have 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 statute of limitations from the date written proof of loss was required to be filed.

M. UNUSUAL CIRCUMSTANCES
If the rendering of services or benefits payable under this Individual Policy 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 Hospital and practitioner Network; (g) epidemic; (h) 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 Provider 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 Individual Policy 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.

VIII. COMPLAINT, GRIEVANCE & APPEAL PROCEDURES

A Complaint is an informal expression of dissatisfaction related to benefits or services provided under this Individual Policy. A Grievance is a formal Complaint regarding service issues or the quality of care. 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 into account the urgency of the Insured’s medical Condition.

COMPLAINT PROCEDURE

Many Complaints can be resolved by using the informal Complaint procedure, which consists of personal and informal discussion about the problem. The Insured or their 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.

GRIEVANCE PROCEDURE

Grievances related to service issues or quality of care must be submitted within one (1) year of the event causing the Grievance. To file a written Grievance, the Insured or their authorized representative must submit a Grievance containing the following information:

1. The Insured’s 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. The Insured’s (or legal representative’s) signature;
5. The date the Grievance is signed.

Formal Grievances may be sent to:

Health First Health Plans – FHCA Fax: (844) 522-5279
ATTN: Grievance Coordinator Email: FHCA@Health-First.org
6450 U.S. Highway 1
Rockledge, FL 32955
Grievances may also be filed verbally by contacting Customer Service at (844) 522-5279 (toll-free) Monday – Friday from 8 a.m. to 8 p.m. or Saturday from 8 a.m. to noon.

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

**APPEAL PROCEDURE – GENERAL INFORMATION**

If benefits are denied in whole or in part, the Health Plan will provide the Insured or their 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 the Insured's health or ability to regain maximum functioning. The Health Plan reserves the right to determine if the Insured’s 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.

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

**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, the Insured or their authorized representative should submit a written Appeal containing the information listed below. Expedited Appeals may be submitted verbally.

1. The Insured’s 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. The Insured’s or authorized representative’s signature;

5. The date the Appeal is signed.

Written Appeals may be sent to:

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

Expeditied Appeals may be filed verbally by contacting an Appeal Coordinator at (844) 522-5279 (toll-free) Monday – Friday from 8 a.m. to 5 p.m.

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 the Insured’s medical Condition requires, but in no longer than seventy-two (72) hours. Verbal notice of the decision will be provided within a 72-hour time frame, with a written decision provided within three (3) days after the verbal notification.

Extensions: One fourteen (14) day extension is permitted if additional information is necessary to make a decision on the Appeal, and the Insured or their 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.

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, an Insured or their 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 the Insured’s 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, the Insured or their authorized representative must contact the Health Plan by writing to the address or calling the number below:

Health First Health Plans - FHCA Phone: (844) 522-5279
ATTN: Appeal Coordinator Fax: (855) 328-0053
6450 U.S. Highway 1 E-Mail: FHCA@Health-First.org
Rockledge, FL 32955

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

1. The individual 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);

2. The Appeal must not be related to the individual’s eligibility under the terms of the plan;

3. The Appeal must be related to a Medically Necessity determination, or whether a requested item or service is experimental or investigational;

4. The internal Appeal process must have been completed, or deemed completed by the Health Plan;

5. All information and forms required to process the external review must be provided.

Within one (1) business day after completing the preliminary review, the Health Plan will notify the Insured or their 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 the Insured or their authorized representative in writing of the Appeal’s acceptance for external review and of their right to submit additional information. The final decision will be issued within forty-five (45) days after receiving the request. For Expedited Appeals, the IRO will notify the Insured or their authorized representative of the decision as quickly as the individual’s 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.

ADDITIONAL ASSISTANCE WITH GRIEVANCES & APPEALS

The Insured or their authorized representative has the right to contact, at any point throughout this process, the State of Florida Department of Financial Services.

Florida’s Department of Financial Services:

Department of Financial Services
Division of Consumer Services, 5th Floor
200 East Gaines Street
Tallahassee, Florida 32399-0327
(877) 693-5236

IX. THE HEALTH PLAN PHARMACY PROGRAM

Coverage for Prescription Drugs and supplies is provided through the Health Plan 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 applicable Calendar Year Prescription Drug Deductible must be satisfied. Once the Calendar Year Prescription Drug Deductible has been satisfied, you must pay, at the time of purchase, the applicable Copayment or Coinsurance percentage of the Participating Pharmacy Allowance or non-Participating Pharmacy Allowance, as applicable, indicated on the Schedule of Benefits for each Prescription.

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. 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 Pharmacy/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 Pharmaceutical Services Department.

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. Medically Necessary, and

4. 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 Agreement.

CONTRACEPTIVE COVERAGE

Oral, transdermal, intravaginal, and intramuscular contraceptives will be Covered under this Agreement. 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 Agreement. Insulin is only Covered if prescribed by a Physician or other Health Care Provider 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 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 in the Formulary with a NCS (No Cost-Share) designee.

**C. 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 Agreement:

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” and 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 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 Agreement.

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.

6. Mineral supplements, fluoride or vitamins, except for supplements 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 Insureds affected by the change.

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

**D. PAYMENT RULES**

Under the Health Plans 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 Prescription Drug Deductible 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.

**E. PHARMACY ALTERNATIVES**

For purposes of this section, there are two (2) types of Pharmacies: Participating Pharmacies and Non-Participating Pharmacies.

**PARTICIPATING PHARMACIES**

Participating Pharmacies are Pharmacies participating in the Health Plan 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 Schedule of Benefits. With the Health Plan Pharmacy Program, there are two (2) types of Participating Pharmacies:

1. Pharmacies within our Network that have signed a the Health Plan 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 this Agreement 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**

A Mail Order Pharmacy is a Pharmacy that has signed a Mail Services Prescription Drug Agreement with us. For additional details on how to obtain Covered Prescription Drugs and supplies from the Mail Order Pharmacy, please refer to the 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 the 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 any applicable Calendar Year Prescription Drug Deductible, Copayment or Coinsurance percentage of the Non-Participating Pharmacy Allowance set forth in the Out-of-Network Cost-Share column in the Schedule of Benefits.

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:

Health First Health Plans - FHCA  
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 Physician if pill-splitting is right for you. If so, ask your Physician 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 would 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 fifty (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, 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 Agreement. 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 Agreement 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 Agreement. 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.

ADVANCED PREMIUM TAX CREDIT (APTC) means a tax credit that can help you afford Coverage bought through the Marketplace. Sometimes known as APTC, “advance payments of the Premium tax credit,” or Premium tax credit. Unlike tax credits you claim when you file your taxes, these tax credits can be used right away to lower your monthly Premium costs. If you qualify, you may choose how much advance credit payments to apply to your Premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you are due, you will get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

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.

AGREEMENT means this Individual Policyholder Evidence of Coverage, which includes the Enrollment Application, Evidence of Insurability and any amendments attached hereto.

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) members. The Allowable Fee Schedule is subject to change without prior notice to affected Insureds.

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 notice to you or your consent.

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 you, 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, but not necessarily limited to:

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 Plan’s 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 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 Agreement 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 Agreement apply. You should refer to the Covered Services section of this Agreement 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.

**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, the primary purpose of which 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.

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

**APPLICANT** means the person or persons who are petitioning the Health Plan for Coverage under this Agreement.
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.

BARIATRIC SURGERY is surgery to treat obesity, which includes procedures such as gastric banding and gastric bypass.

BEHAVIORAL HEALTH PROVIDER means a licensed organization or professional providing diagnostic, therapeutic or psychological service for behavioral health conditions.

BENEFIT YEAR means a year of benefits Coverage under an individual health insurance plan. The Benefit Year for plans bought inside or outside the Health Insurance Marketplace begins January 1 of each year and ends December 31 of the same year. Your Coverage ends December 31, even if your Coverage started after January 1. Any changes to benefits or rates to a health insurance plan are made at the beginning of the Benefit Year.

BILLED CHARGES means the dollar amount billed by a Provider for treatment, services or supplies rendered.

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 is 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 non-proprietary 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. Any changes to benefits or rates to a health insurance plan are made at the beginning of the Calendar 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 infraction, coronary occlusion or coronary bypass surgery.

**CATASTROPHIC HEALTH PLAN** means a health plan that meets all of the requirements under the Affordable Care Act, including coverage of the essential health benefits, but that does not cover any benefits other than three (3) primary care visits per year before the plan's Deductible is met. The Premium for a Catastrophic Health Plan is generally lower than for other QHPs; however, the out-of-pocket costs for Deductibles, Copayments, and Coinsurance are generally higher. To qualify for a Catastrophic Health Plan, you must be under thirty (30) years old OR get a "hardship exemption" because the Marketplace determined that you are unable to afford health coverage.

**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 Agreement.

**COINSURANCE** is the sharing of Covered health care expenses between the Health Plan and you, 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 your Calendar Year Deductible requirement is met, we will pay a percentage of the Allowed Amount for Covered services, as listed in your Schedule of Benefits.

**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 Agreement 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 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, complications of pregnancy, or bodily dysfunction of an Insured.

**CONFINEMENT** is 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.

**COPAYMENT** means the amount payable by the Insured at the time a Covered Service is rendered or a Prescription Drug is obtained from a Pharmacy. Copayment amounts, if applicable, are set forth in the Schedule of Benefits and any Amendment attached to this Agreement. The Copayment is normally expressed as a flat dollar amount and will apply in full, regardless of the amount of the actual charges. Certain Covered Services and Prescription Drugs are subject to the Calendar Year Deductible prior to the Copayment applying.

**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 Amendment attached to this Agreement. Cost-Share may include any applicable combination of Deductibles, Coinsurance and Copayments, up to the Out-of-Pocket Maximum Limit.

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

**COVERED DEPENDENT** means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually Covered, under the Agreement other than as the Policyholder. See the Eligibility Requirements for Dependents subsection of the Eligibility section of this Agreement for more information.

**COVERED PERSON** means a Policyholder or a Covered Dependent.

**COVERED PRESCRIPTION DRUG** means a Drug, which, under federal or state law, requires a Prescription and which is Covered under the Health Plan Pharmacy Program.
COVERED SERVICES means those Medically Necessary services and supplies described in the Covered Services section of this Individual Policyholder Evidence of Coverage and any Amendment attached hereto.

CREDITABLE COVERAGE means health care coverage which is continuous to a date within sixty-two (62) days of your enrollment date. Such health care coverage may include any of the following:

1. A group health insurance plan;
2. Individual health insurance;
3. Student health insurance;
4. Medicare Part A and Part B;
5. Medicaid;
6. CHAMPUS and TRICARE;
7. The Federal Employees Health Benefits Program;
8. Benefits to an Insured and certain former Insured of the uniformed services and their dependents;
9. A medical care program of the Indian Health Service or of a tribal organization;
10. A State health benefits risk pool;
11. A health plan offered under Chapter 89 or Title 5, United States Code;
12. A public health plan;
13. A health benefit plan of the Peace Corps;
14. Children's Health Insurance Program (CHIP);
15. Public health plans established by the federal government; or
16. Public health plans established by foreign governments.

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. Activities of daily living may 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 which you must actually pay each Calendar Year to an appropriate licensed Health Care Provider before the Health Plan’s payment for Covered Services 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.

**DOMESTIC PARTNER** means an adult of the same or opposite sex whom the Policyholder is in a Domestic Partnership.

**DOMESTIC PARTNERSHIP** means the relationship between the Policyholder and another adult of the same or opposite sex that satisfies all of the following criteria:

1. Are in a mutually exclusive relationship similar to marriage and intend to stay in that relationship for an indefinite period;
2. Take responsibility for one another’s welfare;
3. Have not entered into the partnership for the primary purpose of obtaining health insurance;
4. Are eighteen (18) years of age or older and are capable to enter into contracts;
5. Are not blood relatives to the extent that would forbid them from being married in the state of Florida;
6. The Policyholder and partner are both not married, legally separated, or have been party to divorce proceedings or annulment in the last six (6) months; and
7. The Policyholder and partner are not currently registered in or have a Domestic Partnership with someone else, and if either has been in a previous Domestic Partnership, at least six (6) months have passed since the effective date of the termination of that registration or Domestic Partnership;

**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.

**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** is the date upon which a Covered Person becomes eligible for the services provided under this Agreement.

**ELIGIBLE DEPENDENT** means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Dependents subsection of the Eligibility section in the Agreement.

**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 under this Agreement.

**ENTERAL/PARENTERAL NUTRITION THERAPY** which involves feeding via a tube into the gastro-intestinal 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 you; or
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; or

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; or

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; or

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; or

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; or

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 you 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; or

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 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 Statues 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 or 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 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.

GRACE PERIOD means the period immediately following the Health Plan Premium due date during which Health Plan Premiums may be paid without penalty and Coverage under this Agreement continues in effect. Qualified individuals receiving an Advanced Premium Tax Credit (APTC) through the Health Insurance Marketplace have a ninety (90) calendar day Grad Period. All other Insureds have a thirty (30) calendar day Grace Period.

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

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.

HEALTH BENEFIT PLAN means the Health Plan of Covered Services described in this Agreement.

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 Agreement.

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 or 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 Agreement. 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 Agreement) 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 of 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 Agreement.

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 Agreement 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 Policyholder or their Covered Dependents who are Covered under this Individual Policyholder Evidence of Coverage.

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.

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 an Applicant or Covered Person which would have affected our decision to issue this Agreement, issuance of different benefits, or issuance of this Agreement only at a higher rate had they been known.

MEDICAL COMMUNITY means a majority of Physicians who are Board Certified in the appropriate specialty.

MEDICAL EMERGENCY means as 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 Agreement 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 Agreement as determined by us. In applying the definition of Medical Necessity in this Agreement, 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.

**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 an Insured of any religious denomination who provide counseling services.
MENTAL AND NERVOUS DISORDER means any disorder listed in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical modification (ICD-10 CM), or their equivalents in the most recently published version of the America Psychiatric Association’s Diagnostic and Statistical manual of Mental Disorders, regardless of the underlying cause, or effect, of the 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 on behalf of a party held responsible for an Injury or illness to an Insured.

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 Pharmacy Network.

NON-PARTICIPATING PROVIDER means a non-participating Health Care Provider (Hospital, Physician, Physician extender, Pharmacy, or other Provider) that 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 License 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.
OPEN ENROLLMENT PERIOD means the period of time, as determined by the Health Insurance Marketplace, during which individuals who are eligible to enroll can enroll in a plan offered by the Health Plan or in a plan offered through the Marketplace. Each year, individuals have a chance to make changes to their coverage in the Marketplace during Open Enrollment. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment if they experience certain events.

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 Agreement.

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 Policyholder or Covered Dependent 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 charges over the Allowed Amount for Out-of-Network services, expenses related to charges for services not Covered by this Individual Policy, 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.

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 Primary Care Physician. Determination of Partial Disability shall be made by the Primary Care 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 the Health Plan Policyholders and their Covered Dependents under this Agreement. This includes a participating Hospital, a participating Physician, or a 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 Agreement 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.

**POLICYHOLDER** means a person who meets and continues to meet all applicable eligibility requirements, pays the required premiums and who is enrolled and covered under the Agreement, other than as a Covered Dependent.
POST-SERVICE CLAIM means any request or application for Coverage or benefits for a service that has been provided to you and with respect to which the terms of this Agreement condition payment for the service (in whole or in part) on approval by us of Coverage or benefits for the service before you receive it. 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 the Preferred Formulary tier then in effect. The Preferred tier is contained within the Formulary.

PREMIUM means the amount established by the Health Plan to be paid to the Health Plan by the Policyholder or on behalf of the Policyholder in consideration of the benefits provided under this Health Benefit 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 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) is a Family Practitioner, Internist, Pediatrician or Physician Extender (Physician Assistant or Nurse Practitioner) licensed to provide, prescribe, and authorize care and treatment for participants. A current listing of contracted Primary Care Physicians is published in the Plan’s Provider Directory as “Participating”.

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 agreement.

PROVIDER DIRECTORY means a listing of all contracted Participating Providers for the Plan of which you are an Insured. Copies of this Directory 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 Agreement, 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 Agreement, the initial breast reconstruction following 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.

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 is all of Volusia and Flagler Counties.

SICKNESS means bodily disease for which expenses are incurred while Coverage under this Health Plan is in force.

SKILLED NURSING CARE means skilled nursing service, 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 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. Is licensed as a Skilled Nursing Facility by the state of Florida or a similar applicable law of another state.
5. Is 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 State 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.

SPECIAL ENROLLMENT PERIOD (SEP) means a time outside of the Open Enrollment Period during which you and your family have a right to sign up for health coverage or make changes to your health insurance plan following certain life events that involve a change in family status (for example, a marriage or birth of a child). If you qualify for a Special Enrollment Period and do not make the necessary changes to your health insurance during the Special Enrollment Period, you will have to wait until the next Open Enrollment Period to make any changes. To see if you qualify for a Special Enrollment Period, contact the Health Plan or visit www.HealthCare.gov.

SPECIALIST(S) means as a Physician 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 Agreement, 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 Injury or disability if left untreated.

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 Insureds consistent with the provision of quality care in the most cost-effective manner available.

WE, US, OUR means Health First Health Plans, Inc. d/b/a Florida Hospital Care Advantage.

YOU, YOURS means the Policyholder and Covered Dependents who are Covered under this Health Benefit Plan.