

AvMed Health Plans

Policy for

Health Maintenance Organizations

**STATE OF FLORIDA
EMPLOYEES' GROUP INSURANCE PROGRAM**

Effective January 1, 2007

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ADMINISTRATIVE PROVISIONS

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

1. Who is eligible for benefits under this Health Plan, when coverage becomes effective, when coverage terminates, and what the covered person can do to continue coverage or convert to other coverage;
2. How this Health Plan shall relate to other plans under which covered persons have coverage or other situations where payment is made for the services covered under this Health Plan; and
3. How the covered person can appeal to the Health Plan and the state on benefit decisions.

ELIGIBILITY AND EFFECTIVE DATES

Because this coverage is group coverage, eligibility for coverage is tied to the individual's relationship with the state. In addition, the individual must reside in the Health Plan's service area unless, by mutual agreement between the state and the Health Plan, the individual is allowed to enroll in the county where the individual works. The following sections explain eligibility and effective dates of this coverage.

ELIGIBILITY UNDER THE HEALTH PLAN

To be eligible for coverage under this Health Plan, an individual shall be either:

1. An **employee**, which means any state officer or an individual who works for the state on a full-time or part-time basis and who is filling a salaried position, but in no case shall the term eligible employee include persons paid from other personal services (OPS) funds.
2. A **retiree**, which means any state officer or state employee who retires under a state of Florida retirement system or a state optional annuity or retirement program or is placed on disability retirement under the state of Florida retirement system and who was insured under the state group insurance program at the time of retirement and who begins receiving retirement benefits immediately after retirement from state office or employment. Eligible retiree also means a person who retired prior to January 1, 1976, under any of the state administered retirement systems and who is not eligible to receive any benefits under social security.
3. A **surviving spouse**, which means the following:
 - a. The widow or widower of an employee or retiree if such widow or widower was covered as a dependent under the family coverage of the employee or retiree at the time of the employee's or retiree's death;
 - b. The widow or widower of an employee or retiree who died prior to July 1, 1979; or
 - c. The widow or widower of a person who retired prior to January 1, 1976, under any of the state administered retirement systems and who is not eligible to receive any benefits under social security; and
 - d. Any such widow or widower shall cease to be a surviving spouse upon his or her re-marriage.
4. A **dependent**, which means the following:
 - a. The wife or husband of the employee and any eligible children;
 - b. The wife or husband of the retiree and any eligible children;
 - c. The eligible children of a surviving spouse; and
 - d. The newborn children of an eligible child provided such newborn children are born on or subsequent to October 1, 1984. Coverage for such newborn children shall terminate 18 months after the birth of the newborn children.
5. A **child**, which means the employee's or retiree's unmarried own child, adopted child or child placed in the employee's or retiree's home for the purpose of adoption in accordance with chapter 63, Florida Statutes, a step-child who the employee can claim as an exemption on his or her federal income tax return, a child for whom legal guardianship has been established pursuant to chapter 744, Florida Statutes, a foster child, or any other unmarried child for whom the employee or retiree has been granted court ordered temporary or other custody. Such children shall be eligible for coverage as follows:
 - a. From their date of birth to the end of the month in which their 19th birthday occurs;
 - b. From their 19th birthday to the end of the calendar year in which their 25th birthday occurs, if the eligible employee, retiree, or surviving spouse can claim such children as an exemption on his or her federal income tax return and such children are either living with the eligible employee, retiree, or surviving spouse or are

enrolled in any school, college, or university which provides training or educational activities and which is certified or licensed by a state or foreign country;

- c. Children who are mentally or physically handicapped shall be eligible to continue coverage after attainment of the above age limits and while the employee's or retiree's family coverage is in effect provided such children are incapable of self-sustaining employment by reason of such mental or physical handicap and chiefly dependent upon the employee, retiree, or surviving spouse for support and maintenance; or
- d. Children who are over the above age limits at the time of the employee's or retiree's initial enrollment and who are mentally or physically handicapped shall be eligible for coverage if they are incapable of self-sustaining employment by reason of such mental or physical handicap and chiefly dependent upon the employee, retiree, or surviving spouse for support and maintenance; and
- e. When an eligible child marries, all coverage shall cease for that child at the end of the month in which the marriage occurs.

The Health Plan shall be responsible for: (1) requesting, verifying, and maintaining documentation for eligible children who reach the maximum age requirements to determine school enrollment or handicap status; and (2) when a determination is made that a child is no longer eligible as a dependent, notifying the member, in writing, that they have 30 days from the date of the letter to notify the People First Service Center of this change. Additionally, the health plan shall not terminate a dependent determined not eligible until official termination is received from the Division of State Group Insurance or its agent or appropriate documentation is received verifying eligibility, however, payment of claims may be suspended.

ENROLLMENT PERIODS

There are three types of time periods for coverage enrollment under this Health Plan:

1. The **initial enrollment period** is the period of time during which an employee is first eligible to enroll and begins on the employee's initial date of employment and ends 60 calendar days later. If the employee is a state officer, such officer may enroll within 60 calendar days after he or she begins a new term of office.
2. The **annual open enrollment period** is the period of time designated each calendar year during which: 1) eligible employees may enroll in the Health Plan or, 2) eligible employees, retirees, surviving spouses or COBRA participants may transfer from their present plan to any other plan available without application of waiting periods or exclusions based on health status as conditions of enrollment or transfer.
3. A **special enrollment period** is the period of time during which eligible employees, retirees, surviving spouses, and COBRA participants may enroll. Special enrollment periods shall be required under the following circumstances:
 - a. To permit the transfer from a defunct plan to another qualified plan; or
 - b. Legislative mandate allowing retired state employees coverage under this Health Plan.

EMPLOYEE ENROLLMENT

Eligible employees who become insured under this Health Plan shall be included in the definition of "covered persons." To become a covered person, the employee shall:

1. Complete and submit, through his or her employing agency or its agent, a written request for coverage, using enrollment forms provided and approved by both the Health Plan and the state; and
2. Agree to pay his or her portion of the required premium, if required by the state.

An employee who is a newly eligible employee shall enroll within the initial enrollment period. An employee, retiree, surviving spouse or COBRA participant who has been covered under another health benefit plan established and maintained by the state, and who now wants to change to this Health Plan, shall enroll for such coverage change during an annual open enrollment period or special enrollment period.

EMPLOYEE EFFECTIVE DATE

The effective date of coverage for enrollment in this Health Plan shall be the first day of the month after the month in which a full month's premium has been received by the Division of State Group Insurance or its agent.

DEPENDENT EFFECTIVE DATE

The effective date of a dependent's coverage under this Health Plan depends on when the dependent is enrolled:

1. If the dependent is eligible for coverage on the group effective date, coverage for the dependent shall become effective on the group effective date if the employee enrolls the dependent for coverage at the same time he or she enrolls during the initial enrollment period.
2. If the employee through whom the dependent is eligible first becomes eligible after the group effective date and the employee enrolls himself or herself and his or her dependents during the initial enrollment period, coverage for the dependents shall be effective on the same date that the employee's coverage becomes effective.
3. The effective date of coverage for a dependent of a covered employee shall be the date of birth or acquisition when:
 - a. the covered employee has family coverage;
 - b. the dependent becomes eligible after the covered employee's effective date; and
 - c. the covered employee enrolls the dependent within 60 days after eligibility as a dependent begins.
4. The effective date of coverage for a dependent of a covered employee enrolled in individual coverage shall be:
 - a. the date of birth or acquisition; and
 - b. the first day of the month after the month in which a full month's premium for family coverage has been received by the Division of State Group Insurance or its agent.

If, on the date dependent coverage becomes effective, the dependent is covered for a condition under an extension of group health benefits from a previous employer-related health plan, health insurance plan, or other coverage arrangement, coverage under this Health Plan, for extension related services or supplies for that condition, shall not begin until the extension under the prior plan ends.

PRE-EXISTING CONDITION LIMITATIONS

For health maintenance organizations under contract with the state, pre-existing condition limitations do not apply.

COVERAGE FOR NEWBORN CHILDREN

All health benefits applicable for children under this Health Plan shall be provided with respect to the newborn child of the covered person or to a covered dependent from the moment of birth if the covered person has family coverage. However, with respect to the newborn child of a covered dependent of the covered person other than the covered person's spouse, the coverage for the newborn child terminates 18 months after the birth of the newborn.

The coverage for newborn children shall consist of coverage for injury or sickness, including medically necessary care or treatment for medically diagnosed congenital defects, birth abnormalities, or prematurity, and the transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition. Such transportation shall be certified by the attending physician as necessary to protect the health and safety of the newborn child.

The Division of State Group Insurance or its agent shall be notified, in writing, within 60 days after the birth. Coverage shall not be denied for a newborn child due to the covered person's failure to provide notice within the 60 day period of the birth of the child if the covered person has family coverage. However, covered persons with individual coverage shall convert to family coverage prior to the birth of the newborn child. If the newborn child is born prior to the conversion to family coverage, only well-baby hospital nursery services shall be eligible for coverage.

COVERAGE FOR ADOPTED CHILDREN

All health benefits applicable to children shall be provided with respect to a child adopted by the covered person if the covered person has family coverage:

1. From the moment of placement in the covered person's residence in compliance with chapter 63, Florida Statutes; and
2. From the moment of birth, if a written agreement to adopt such newborn child has been entered into prior to the birth of the child.

Notice of the birth or placement of the child shall be given to the state, in writing, no later than 31 days after the occurrence. Coverage shall not be denied for a child due to the covered person's failure to provide timely notice of birth or placement of the child if the covered person has family coverage. However, covered persons with individual coverage shall convert to family coverage prior to the birth or placement of the adopted child. If the adopted newborn child is born prior to the conversion to family coverage, only well-baby hospital nursery services shall be eligible for coverage. Covered services for the adopted child shall be the same as any other dependent child.

COVERAGE FOR FOSTER CHILDREN

Coverage for a foster child or a child otherwise placed in the covered person's custody by a court order shall be provided from the date of placement if on the date of placement the covered person has family coverage. However, covered persons with individual coverage shall convert to family coverage prior to the placement of the foster child. If the foster newborn child is born prior to the conversion to family coverage, only well-baby hospital nursery services shall be eligible for coverage. Covered services for the foster child shall be the same as any other dependent child. No coverage shall be provided under this provision for the child who is not ultimately placed in the covered person's home. For children in the covered person's custody, coverage shall terminate the date the covered person no longer has legal custody.

DEPENDENT CHILD AS EMPLOYEE

A covered dependent child shall be eligible as a covered employee as long as he or she meets the eligibility requirements for a covered employee. However, a covered dependent child may be insured as a dependent if the covered parent can claim such child as an exemption on his or her federal income tax return and if such child meets all eligibility criteria for a dependent child under this Health Plan. A dependent child shall not be covered under this Health Plan as a dependent of more than one employee.

TERMINATION OF COVERAGE

The termination of coverage depends on the decisions of the state and on the covered person's continued employment relationship to the state. The following sections explain when coverage shall end and the options available to the covered person to continue or convert coverage.

COVERAGE TERMINATION

The coverage under this Health Plan for any covered person shall end at 12:01 a.m., local standard time, on the earliest of the following dates:

1. The contract between the state and the Health Plan ends;
2. The state fails to pay the premium due;
3. The covered person otherwise fails to continue to meet each of the eligibility requirements under this Health Plan;
4. The covered person's membership is terminated for cause;
5. The covered person no longer resides in the Health Plan's service area; or
6. The covered person becomes covered under another health benefit plan which is established and maintained through or in connection with the state as an alternative to this Health Plan.

DEPENDENT COVERAGE TERMINATION

The coverage under this Health Plan for any covered dependent shall end automatically at 12:01 a.m., local standard time, on the earliest of the following dates:

1. The contract between the state and the Health Plan ends;
2. The covered person's coverage ends for any reason;
3. The dependent fails to continue to meet each of the dependent eligibility requirements under this Health Plan;
4. The covered dependent's membership is terminated for cause;
5. The covered dependent no longer resides in the service area with the exception of covered dependents who are full-time or part-time students outside the service area; or
6. The dependent becomes covered under another health benefit plan which is offered through the state as an alternative to this Health Plan.

HANDICAPPED CHILDREN COVERAGE TERMINATION

If a child attains the limiting age for a covered dependent, coverage shall not terminate while that person is, and continues to be, both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly dependent on the covered person for support and maintenance.

If health benefits are denied for the stated reason that the child has reached the limiting age for dependent coverage, the covered person shall have the burden of establishing that the child is and has continued to be handicapped.

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

TERMINATION OF COVERAGE FOR CAUSE

If, in the Health Plan's opinion, any of the following events occur, the Health Plan may request that the state terminate a covered person for any of the following reasons:

1. Disruptive, unruly, abusive, or uncooperative behavior to the extent that such covered person's continued membership in the Health Plan impairs the Health Plan's ability to administer this plan or to arrange for the delivery of health care services to such covered person or to other covered persons if:
 - a. an effort has been made to resolve the problem;
 - b. consideration has been given to extenuating circumstances; and
 - c. the problems, efforts, and medical conditions have been documented;
2. Fraud or material misrepresentation or omission in applying for membership or in requesting the receipt of coverage; or
3. Misuse of the membership identification card.

Any termination made under this provision is subject to review in accordance with the grievance procedures described in this Health Plan.

RIGHTS TO EXTENSION, CONVERSION AND CONTINUATION

If coverage for a covered person ends, the covered person may, depending on his or her situation, have the right to have coverage extended under the extension of benefits provision. Also, the covered person may be eligible for coverage under the federal continuation of coverage provisions or an alternative coverage plan under the conversion privilege provision.

EXTENSION OF BENEFITS (Post Termination Disability Coverage)

If the Health Plan terminates its contract with the state, extension of benefits shall be provided in accordance with applicable statutes.

EXTENSION OF MATERNITY BENEFITS

If the Health Plan terminates its contract with the state, extension of benefits shall be provided in accordance with applicable statutes.

EXTENSION OF HOSPITAL INPATIENT BENEFITS

The HMO shall extend coverage to a member who is a hospital inpatient on the date the HMO's contract is terminated. However, the HMO shall not be required to provide such extended hospital benefits beyond 12 calendar months from the date the contract is terminated. This provision applies if the HMO terminates its contract with the State but not if the employee terminates coverage with the HMO.

FEDERAL CONTINUATION PROVISIONS

Federal law permits covered persons to continue coverage under an employer established health benefit plan under certain circumstances. This law is referred to as COBRA, which stands for the "Consolidated Omnibus Budget Reconciliation Act of 1985" and includes any amendments thereto.

It shall be the state's responsibility to inform employees of their rights under COBRA. Information on employee COBRA rights may also be obtained from the United States Department of Labor.

THE CONVERSION PRIVILEGE

Covered persons whose coverage under this Health Plan has terminated for any reason other than for non-payment of premium shall have the right to apply for a conversion policy.

The new conversion plan shall be a benefit plan in use by the Health Plan for group conversions on the date of the request. The new coverage shall be issued at the rates for the Health Plan's conversion policies as filed and approved by the Florida Office of Insurance Regulation on the date coverage under this Health Plan terminates.

REQUESTING CONVERSION

A covered person who is eligible for conversion shall obtain conversion coverage without having to submit evidence of health qualification. The covered person shall apply in writing and pay the first premium on the conversion plan within 31 days after his or her coverage under this Health Plan terminates. The application form to be used and information about conversion benefits shall be obtained from the Health Plan.

Conversion shall not be available if:

1. Coverage under this Health Plan ends due to failure to pay any required premium;
2. This Health Plan is replaced by similar group coverage within 31 days of the termination date of this Health Plan;
3. The covered person is or could be covered by Medicare; or
4. The covered person is eligible for the following coverages and those benefits together with the benefits provided by the conversion plan would result in excessive duplication of benefits, such as:
 - a. Any arrangements of coverage for individuals in a group whether on an insured or self-insured basis;
 - b. Similar benefits under any state or federal program; or
 - c. Similar benefits by another group hospital, surgical, medical or major medical expense insurance policy or group hospital and medical service plan or group medical practice or any other prepayment plan or program.

THIS HEALTH PLAN AND OTHER PAYMENT ARRANGEMENTS

COORDINATION OF BENEFITS

When a covered person is covered under this Health Plan and another health coverage plan, the Health Plan shall reserve the right to coordinate the benefits of this Health Plan with the benefits of the other health plan. This provision explains how coordination shall take place.

Coordination of benefits is designed to avoid the costly duplication of payment for health care services and/or supplies under multiple health coverage plans. The sum of the benefits that will be payable under all plans shall not exceed 100 percent of the total allowed expenses actually incurred.

PLANS AFFECTED

If a covered person has any other health plan which covers at least a portion of a health care service or supply which is covered under this Health Plan, coordination shall take place. Not all health coverage plans shall be considered in this coordination process. The plans that shall be considered are the following:

1. Any group insurance, group self-insurance or health maintenance organization plan; including coverage under labor-management, trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans;
2. Any service plan contracts, group practice, individual practice, or other prepayment coverage on a group basis;
3. Any plan, program or insurance established pursuant to workers' compensation legislation or other legislation of similar purpose;
4. Any non-group insurance policy, including an automobile insurance policy, provided that policy contains a coordination of benefits provision; or
5. Any coverage under governmental programs including Medicare, and any coverage required or provided by any statute.

Each policy, plan, or other arrangement with coverage for medical benefits or services that the covered person has shall be considered separately when determining the coordination of its benefits with this Health Plan. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed a paid benefit.

ORDER OF BENEFIT DETERMINATION

If the health benefits of all of the health coverage plans under which the covered person is covered exceed 100 percent of the total reasonable expenses actually incurred, the coordination process shall reduce the payment of one or more of the plans to eliminate any excess payment. The following guidelines shall be used to determine the order in which companies shall be considered and the appropriate benefit payment:

1. The first guideline is dependent status. The plan which covers the person receiving the service as an employee shall be the primary payor before the plan which covers the person as a dependent;
2. The second guideline is the "parent birth date rule" used in the case of a dependent child covered under both parent's plans and the parents are not divorced. The plan of the parent whose date of birth, excluding year, occurs earlier in the calendar year shall be the primary payor before the plan of the parent whose date of birth, excluding year, occurs later in a calendar year. If both parents have the same birth date, the plan with the earliest effective date shall be the primary payor. If one of the plans is administered in a state that does not use the parent birth date rule, the "gender rule" shall apply. The male parent's plan shall be primary.
3. In the case of a claim made for a dependent child whose parents are separated or divorced, the divorce decree shall establish the primary payor, or:
 - a. If the divorce decree orders the parents to share equal responsibility, the plan of the parent with custody shall be the primary payor; or
 - b. If the divorce decree orders the parents to have joint custody and responsibility, the plan with the earliest effective date for the child shall be the primary payor.
4. If there is no divorce decree, the plan of the parent with custody shall be primary. If the parent with custody remarries, the order of payment shall be: 1) plan of the parent with custody, 2) plan of step-parent, and 3) plan of parent without custody.
5. When rules 1, 2, 3 or 4 do not establish an order of benefit payment, the plan which has covered the person for the longer period shall be primary payor before the plan which has covered such person the shorter period of time, provided that:
 - a. The plan covering the person as an active employee shall be payable before any other plan covering such person as a laid-off or retired employee or dependent of such person;
 - b. The plan which had covered the retired covered person as an active employee shall be payable before any other plan covering such person as a dependent of another retired person; or
 - c. If either plan does not have an order of determination provision regarding laid-off or retired employees then the provisions of 5.a. above shall not apply.

SUBROGATION

Situations that cause a covered person to need the benefits and supplies provided under this Health Plan may also result in actions by the covered person to recover damages related to that situation. Such actions may often result in duplicate payments for the services and supplies that the Health Plan has already provided to the covered person.

To protect the Health Plan from this type of duplicate payment, the Health Plan reserves the right to become involved in that recovery process. The Health Plan's right to become involved is called "subrogation."

1. If the Health Plan has paid for services or supplies under this Health Plan, the covered person shall, to the extent of such services or supplies, have subrogated the Health Plan to all causes of action and rights of recovery that the covered person may have or has against any persons and/or organizations that are related to the incident that necessitated the rendering of the services or supplies. These subrogation rights extend and apply to any settlement of a claim, irrespective of whether litigation has been initiated.
2. The covered person shall promptly execute and deliver instruments and papers related to these subrogation rights as requested by the Health Plan. Further, the covered person shall promptly notify the Health Plan of any settlement negotiations prior to entering into a settlement agreement affecting the Health Plan's subrogation rights.
3. In no event shall a covered person fail to take any action where action is appropriate, or take any action that may prejudice the Health Plan's subrogation rights. No waiver, release of liability, settlement, or other documents executed by a covered person without prior notice to and approval by the Health Plan, shall be binding upon the Health Plan.
4. The Health Plan retains the right to recover such payments and/or the reasonable value of the benefits provided from any person or organization to the fullest extent permitted by law.

RIGHT TO RECEIVE AND RELEASE INFORMATION

The covered person shall give permission for the Health Plan or its representatives to obtain from or release to other insurance carriers or health care providers information necessary for processing claims and/or determining other carrier liability. Covered persons shall cooperate with the Health Plan or its representatives in its effort to obtain such information by, among other ways, signing any release of information form as requested by the Health Plan or its representatives.

FACILITY OF PAYMENT

Whenever payment, which should have been made by the Health Plan, is made by any other plan, the Health Plan shall pay to that other plan any amounts the Health Plan determines to be necessary under the coordination of benefits provision. Amounts paid to another plan in this manner shall be considered benefits paid under this Health Plan. The Health Plan is discharged from liability under this Health Plan to the extent of any amounts so paid.

RIGHT OF RECOVERY

If the Health Plan makes larger payments than are required under this Health Plan, the Health Plan shall have the right to recover any excess benefit payment from any person or organization to or for whom such payments were made, or any other person or organization the Health Plan may determine.

NON-DUPLICATION OF GOVERNMENT PROGRAMS

The benefits of this Health Plan shall not duplicate any benefits to which covered persons are entitled, or for which they are eligible, whether or not received, under governmental programs such as Medicare, Veterans Administration, CHAMPUS, or any Workers' Compensation Act, to the extent allowed by law. In any event, if this Health Plan has duplicated such benefits, all sums paid or payable under such programs shall be paid or payable to the Health Plan to the extent of such duplication.

NON-DUPLICATION OF OTHER COVERAGE

The benefits under this Health Plan shall not duplicate any benefits to which covered persons are entitled by law, and/or for which they are eligible under any extension of benefits and/or coverage provisions of any other plan, policy, program, or contract.

COOPERATION OF COVERED PERSONS

Each covered person shall cooperate with the Health Plan, and shall execute and submit to the Health Plan such consents, releases, assignments, and other documents as may be requested by the Health Plan in order to administer and exercise its rights under the subrogation provision or to process claims. Failure to do so may result in the reduction of benefit payments under this Health Plan.

MEDICARE ELIGIBLES

Medicare Part A means the social security program which provides hospital insurance benefits.

Medicare Part B means the social security program which provides physician and outpatient insurance benefits.

A covered retired person shall be considered eligible for Medicare on the earliest date in which coverage under Medicare could become effective for him or her.

Coordination with Medicare

For a covered retired person who is under age 65 and eligible for Medicare, the benefits payable by this Health Plan shall be reduced so that not more than 100 percent of the Medicare allowance incurred are paid jointly by this Health Plan and Medicare.

For the purposes of determining benefits payable for any covered person who is eligible to enroll for Medicare Part B, but who does not enroll in Medicare Part B, the Health Plan shall assume the amount payable under Medicare Part B to be the amount the covered person would have received if he or she had enrolled in Medicare Part B.

TEFRA Options

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), as amended, allows active state employees age 65 or older and their insured spouses who are eligible for Medicare to choose one of the following options:

Option 1 The benefits of this Health Plan shall be payable first and the benefits of Medicare shall be payable second; or

Option 2 Medicare benefits only. The employee and/or his or her spouse, and his or her dependents, if any, shall not be insured under this Health Plan.

The state shall provide each Medicare eligible employee and/or spouse with the choice to elect one of these options at least one month before the employee and/or spouse becomes age 65. All new Medicare eligible employees and their Medicare eligible spouses shall be offered these options. If option 1 is chosen, coverage shall be subject to the same requirements as for a covered person who is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by this Health Plan differs for each category.

Category I Medicare eligibles are:

1. Actively working covered persons age 65 or older who choose option 1;
2. Their age 65 or older insured spouses; or
3. Age 65 or older insured spouses of actively working covered persons who are under age 65.

For covered persons in category I, benefits shall be payable by this Health Plan without regard to any benefits payable by Medicare. Medicare shall then determine its benefits.

Category II Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled in Medicare. This category includes, but is not limited to:

1. Retired employees over 65 (Medicare I);
2. Retired employees and their covered dependents, one of whom is over 65 (Medicare II); or
3. Retired employees and their spouses both over 65 (Medicare III).

For covered persons in category II, Medicare benefits shall be payable before any benefits shall be payable by this Health Plan. The benefits of this Health Plan shall then be reduced by the full amount of the Medicare benefits the covered person shall be entitled to receive, whether or not they are actually enrolled for those Medicare benefits.

For covered persons, regardless of age or employment status, diagnosed with end stage renal disease (ESRD) the Health Plan shall be primary for the first 30 months after the Medicare Part A effective date. After such date, Medicare shall become the primary payor and the Health Plan shall become secondary payor.

REIMBURSEMENT FOR NON-PARTICIPATING PROVIDER SERVICES

The Health Plan shall provide or arrange for covered services to be received from participating providers on a direct service basis. If a covered person receives covered services from a participating provider, the Health Plan shall pay the provider directly for all care received. The covered person shall not have to submit a claim for payment, and shall be responsible only for any applicable copayments.

In the event the covered person requires emergency services from a non-participating provider while inside or outside the service area or, if the Health Plan refers the covered person to a non-participating provider, the Health Plan shall attempt to arrange for direct payment with the non-participating provider. If the non-participating provider refuses direct payment, or if such arrangements are not possible, the covered person will need to submit a claim to the Health Plan for the services, and shall be reimbursed for the cost of the services. The covered person shall not be reimbursed for more than the actual out-of-pocket expenses related to the services.

The following provisions apply in the event the covered person needs to file a claim for non-participating provider services:

CLAIM FORMS

Claim forms may be required for submission of a proof of loss by a covered person for non-participating provider services.

As this procedure varies for health maintenance organizations, the covered person is responsible for following the procedures established by the Health Plan.

PROOF OF LOSS

For services rendered by non-participating providers, written proof of loss shall be given to the Health Plan. If proof of loss is not submitted and received by the Health Plan within the Health Plan's required time period, the claim may be

reduced or invalidated. If it can be shown that it was not reasonably possible to submit written proof of loss within the allowed time period and that the proof was submitted as soon as possible, the claim shall not be reduced or invalidated.

TIME OF PAYMENT OF CLAIMS

After receiving written proof of loss for a covered service, the Health Plan shall reimburse all uncontested claims or any portion of any claim received by the Health Plan from a covered person or a covered person's assignees within 30 days.

If a claim or portion of a claim is contested by the Health Plan, the covered person or the covered person's assignees shall be notified, in writing. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. The Health Plan, upon receipt of additional information requested from a covered person or the covered person's assignees, shall pay or deny the contested claim or portion of the contested claim within 30 days.

Payment shall be treated as being made on the date a draft or 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.

ASSIGNMENT OF CLAIM

For covered services rendered by non-participating providers, benefits shall be payable to the covered person less any applicable copayments which are the responsibility of the covered person. The Health Plan may pay all or any part of the benefits to the health care provider on whose charge the claim is based. The Health Plan is under no obligation to honor such assignments from non-participating providers.

UNUSUAL CIRCUMSTANCES

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

GRIEVANCE PROCEDURE

URGENT CARE CLAIMS

INITIAL CLAIM – An Urgent Care Claim shall be deemed to be filed on the date received by Health Plan. AvMed shall notify the Claimant of the Health Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Health Plan receives, either orally or in writing, the Urgent Care Claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Health Plan. If such information is not provided, AvMed shall notify the Claimant as soon as possible, but not later than 24 hours after the Health Plan receives the Claim, of the specific information necessary to complete the Claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. AvMed shall notify the Claimant of the Health Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

1. The Health Plan's receipt of the specified information; or
2. The end of the period afforded the Claimant to provide the specified additional information.

If the Claimant fails to supply the requested information within the 48-hour period, the Claim shall be denied. AvMed may notify the Claimant of its benefit determination orally or in writing. If the notification is provided orally, a written or electronic notification, meeting the requirements of the Manner and Content of Initial Claims Determination Notification Section below, shall be provided to the Claimant no later than 3 days after the oral notification.

APPEAL – A Claimant may appeal an Adverse Benefit Determination with respect to an Urgent Care Claim within 180 days of receiving the Adverse Benefit Determination. AvMed shall notify the Claimant, in accordance with the Manner and Content of Appeal Notification Section below, of the Health Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Health Plan receives the Claimant's request for review of an Adverse Benefit Determination.

You may submit an appeal to:

AvMed Member Services – North
P.O. Box 823
Gainesville, Florida 32602-0823
Telephone: 1-800-882-8633
Fax: (352) 337-8612

AvMed Member Services – South
P.O. Box 569008
Miami, Florida 33256-9906
Telephone: 1-800-882-8633
Fax: (305) 671-4736

If you are not satisfied with AvMed's final decision, you may contact the Florida Agency for Health Care Administration (AHCA) or the Department of Financial Services (DFS) in writing within 365 days of receipt of the final decision letter. If you appeal AvMed's decision, your grievance will be reviewed by the Statewide Provider and Subscriber Assistance Program. You also have the right to contact the AHCA or DFS at any time to inform them of an unresolved grievance.

The Statewide Provider and Subscriber Assistance Program will not hear a grievance if the Member has not completed the entire AvMed Grievance process nor if the member has instituted an action pending in the state or federal court.

If you need further assistance, you may contact:

Statewide Provider and Subscriber Assistance Program Panel
Agency for Health Care Administration
HMO Section
2727 Mahan Drive, Mail Stop 26
Tallahassee, Florida 32308
Telephone 1-888-419-3456 or 850-921-5458

Florida Department of Financial Services
200 East Gaines Street
Tallahassee, Florida 32399
Telephone 1-800-342-2762

PRE-SERVICE CLAIMS

INITIAL CLAIM – A Pre-Service Claim shall be deemed to be filed on the date received by Health Plan. AvMed shall notify the Claimant of the Health Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Health Plan receives the Pre-Service Claim. The Health Plan may extend this period one time for up to 15 days, provided that AvMed determines that such an extension is necessary due to matters beyond the Health Plan's control and notifies the Claimant, before the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Health Plan expects to render a decision. If such an extension is necessary because the Claimant failed to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. In the case of a failure by a Claimant to follow the Plan's procedures for filing a Pre-Service Claim, the Claimant shall be notified of the failure and the proper procedures to be followed in filing a Claim for benefits not later than five (5) days following such failure. The Plan's period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information. If the Claimant fails to supply the requested information within the 45-day period, the Claim shall be denied.

APPEAL – A Claimant may appeal an Adverse Benefit Determination with respect to a Pre-Service Claim within 180 days of receiving the Adverse Benefit Determination. AvMed shall notify the Claimant, in accordance with the Manner and Content of Appeal Notification Section below, of the Health Plan's determination on review within a reasonable period of time. Such notification shall be provided not later than 30 days after the Health Plan receives the Claimant's request for review of the Adverse Benefit Determination.

You may submit an appeal to:

AvMed Member Services – North
P.O. Box 823
Gainesville, Florida 32602-0823
Telephone: 1-800-882-8633
Fax: (352) 337-8612

AvMed Member Services – South
P.O. Box 569008
Miami, Florida 33256-9906
Telephone: 1-800-882-8633
Fax: (305) 671-4736

If you are not satisfied with AvMed's final decision, you may contact the Florida Agency for Health Care Administration (AHCA) or the Department of Financial Services (DFS) in writing within 365 days of receipt of the final decision letter. If you appeal AvMed's decision, your grievance will be reviewed by the Statewide Provider and Subscriber Assistance Program. You also have the right to contact the AHCA or DFS at any time to inform them of an unresolved grievance.

The Statewide Provider and Subscriber Assistance Program will not hear a grievance if the Member has not completed the entire AvMed Grievance process nor if the member has instituted an action pending in the state or federal court.

If you need further assistance, you may contact:

Statewide Provider and Subscriber Assistance Program Panel
Agency for Health Care Administration
HMO Section
2727 Mahan Drive, Mail Stop 26
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Telephone 1-888-419-3456 or 850-921-5458

Florida Department of Financial Services
200 East Gaines Street
Tallahassee, Florida 32399
Telephone 1-800-342-2762

POST-SERVICE CLAIMS

INITIAL CLAIM – A Post-Service Claim shall be deemed to be filed on the date received by Health Plan. AvMed shall notify the Claimant, in accordance with the Manner and Content of Initial Claims Determination Notification Section below, of the Health Plan's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after the Health Plan receives the Post-Service Claim. The Health Plan may extend this period one time for up to 15 days, provided that AvMed determines that such an extension is necessary due to matters beyond the Health Plan's control and notifies the Claimant, before the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Health Plan expects to render a decision. If such an extension is necessary because the Claimant failed to submit the information necessary to decide the Post-Service Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. The Plan's period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information. If the Claimant fails to supply the requested information within the 45-day period, the Claim shall be denied.

APPEAL – A Claimant may appeal an Adverse Benefit Determination with respect to a Post-Service Claim within 180 days of receiving the adverse Benefit Determination. AvMed shall notify the Claimant, in accordance with the Manner and Content of Appeal Notification Section below, of the Health Plan's determination on review within a reasonable period of time. Such notification shall be provided not later than 60 days after the Health Plan receives the Claimant's request for review of the Adverse Benefit Determination.

You may submit an appeal to:

AvMed Member Services – North
P.O. Box 823
Gainesville, Florida 32602-0823
Telephone: 1-800-882-8633
Fax: (352) 337-8612

AvMed Member Services – South
P.O. Box 569008
Miami, Florida 33256-9906
Telephone: 1-800-882-8633
Fax: (305) 671-4736

If you are not satisfied with AvMed's final decision, you may contact the Florida Agency for Health Care Administration (AHCA) or the Department of Financial Services (DFS) in writing within 365 days of receipt of the final decision letter. If you appeal AvMed's decision, your grievance will be reviewed by the Statewide Provider and Subscriber Assistance Program. You also have the right to contact the AHCA or DFS at any time to inform them of an unresolved grievance.

The Statewide Provider and Subscriber Assistance Program will not hear a grievance if the Member has not completed the entire AvMed Grievance process nor if the member has instituted an action pending in the state or federal court.

If you need further assistance, you may contact:

Statewide Provider and Subscriber Assistance Program Panel
Agency for Health Care Administration
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Florida Department of Financial Services
200 East Gaines Street
Tallahassee, Florida 32399
Telephone 1-800-342-2762

CONCURRENT CARE CLAIMS

Any reduction or termination by the Health Plan of Concurrent Care (other than by plan amendment or termination) before the end of an approved period of time or number of treatments, shall constitute an Adverse Benefit Determination. AvMed shall notify the Claimant, in accordance with the Manner and Content of Initial Claims Determination Notification Section below, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of the Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that relates to an Urgent Care Claim shall be decided as soon as possible, taking into account the medical exigencies, and AvMed shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after the Health Plan receives the Claim, provided that any such Claim is made to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments. Notification and appeal of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving an Urgent Care Claim or not, shall be made in accordance with Parts II, III or IV, as appropriate, of this Addendum.

MANNER AND CONTENT OF INITIAL CLAIMS DETERMINATION NOTIFICATION

AvMed shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Claimant, the following:

1. The specific reason or reasons for the Adverse Benefit Determination.
2. Reference to the specific Health Plan provisions on which the determination is based.
3. A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary.
4. A description of the Health Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action, when applicable under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") following an Adverse Benefit Determination on final review.
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy shall be provided free of charge to the claimant upon request.
6. If the Adverse Benefit Determination is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Health Plan to the claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request.
7. In the case of an Adverse Benefit Determination involving an Urgent Care Claim, a description of the expedited review process applicable to such Claim.

REVIEW PROCEDURE UPON APPEAL

Health Plan's appeal procedures shall include the following substantive procedures and safeguards:

1. A Claimant may submit written comments, documents, records, and other information relating to the Claim.
2. Upon request and free of charge, the Claimant shall have reasonable access to and copies of any Relevant Document.
3. The appeal shall take into account all comments, documents, records, and other information the Claimant submitted relating to the Claim, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
4. The appeal shall be conducted by an appropriate named fiduciary of the Health Plan who is neither the individual who made the initial Adverse Benefit Determination nor the subordinate of such individual. Such person shall not defer to the initial Adverse Benefit Determination.
5. In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental and/or Investigational or not Medically Necessary, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

6. The appeal shall provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Health Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination.
7. The appeal shall provide that the Health Care Professional engaged for purposes of a consultation in Subsection 7.01.05 shall be an individual who is neither an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
8. In the case of an Urgent Care Claim, there shall be an expedited review process pursuant to which:
 - (a.) A request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and
 - (b.) All necessary information, including the Health Plan's benefit determination on review, shall be transmitted between the Health Plan and the Claimant by telephone, facsimile, or other available similarly expeditious methods.

MANNER AND CONTENT OF APPEAL NOTIFICATION

AvMed shall provide a Claimant with written or electronic notification of the Health Plan's benefit determination on review.

In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Claimant, all of the following, as appropriate:

1. The specific reason or reasons for the Adverse Benefit Determination.
2. Reference to the specific Health Plan provisions on which the Adverse Benefit Determination is based.
3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of any Relevant Document.
4. A statement describing any voluntary appeal procedures offered by the Health Plan and the Claimant's right to obtain the information about such procedures and a statement of the Claimant's right to bring an action, when applicable under ERISA Section 502(a).
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy shall be provided free of charge to the Claimant upon request.
6. If the Adverse Benefit Determination is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Health Plan to the Claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request.

COVERAGE PROVISIONS

This section provides important information on the coverage provided under the Health Plan explaining:

1. What rules the covered person shall follow in accessing care;
2. What services and supplies are covered; and
3. What services and supplies are not covered.

COVERAGE ACCESS RULES

It is important that Health Plan covered persons become familiar with the rules for accessing health care services through the Health Plan. **It is the Member's responsibility when seeking benefits under this Contract to identify himself as an AvMed Health Plan member and to assure that the services received by the member are being rendered by Participating Providers.** The following sections explain the role of the Health Plan and the primary care physician, how to access specialty care through the Health Plan, and what to do if emergency care is needed.

THE ROLE OF THE PRIMARY CARE PHYSICIAN

Typically, the first decision a covered person must make when joining a health maintenance organization is the selection of a Primary Care Physician (PCP). However, while members are encouraged to select one PCP upon enrollment, you are not required to do so. Should you elect to use a PCP, you have the ability to change your PCP at any time. Covered persons are free to choose any PCP listed in the Health Plan's list of PCPs, whose practice is open

to additional Health Plan covered persons. Health Professionals may from time to time cease their affiliation with Health Plan, so you should confirm participation of your selected provider prior to seeking services through the Health Plan's member services staff or via their respective website. The selection or assignment of a PCP varies for health maintenance organizations.

Some important guidelines apply to the covered person's PCP relationship:

1. If chosen, the PCP shall maintain a physician-patient relationship with the covered person.
2. The covered person may look to the PCP to direct his or her care, and should accept procedures and treatment recommended by the PCP.
3. Except in emergency situations or as otherwise directed by the Health Plan, all services shall be received from participating providers, or through another health care provider designated by the Health Plan. If services are not received in this manner and the covered person uses a health care provider that is not a participating provider, services shall not be reimbursed by the Health Plan.
4. If the covered person's PCP terminates his or her agreement with the Health Plan, the Health Plan shall assist the covered person in selecting another primary care physician whose practice is open to new Health Plan covered persons.

OPEN ACCESS TO SPECIALTY HEALTH CARE PHYSICIANS

You are entitled to see most participating Specialty Health Care Physicians without a referral. However, there are certain services provided by Specialty Health Care Physicians that require prior authorization, including some services performed in the office. In addition, self-referral is not permitted to participating Specialty Health Care Physicians designated as "Requires Special Consultation between your Doctor and the AvMed Medical Director" in the written or electronic Provider Directories at the time of service.

EMERGENCY CARE

The procedure the covered person should follow for emergency care, as defined in this section, depends on whether the treatment is rendered inside or outside the service area.

WITHIN THE SERVICE AREA

A medical emergency within the service area is defined as: the sudden and acute onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in permanently placing the covered person's health in jeopardy; serious impairment to bodily function; serious and permanent dysfunction to a body organ or part; or other serious medical consequences.

Symptoms must occur suddenly and unexpectedly and must be sufficiently severe to cause a covered person to seek medical assistance, regardless of the hour of day or night. Examples of medical emergencies are heart attacks, cerebrovascular accidents, poisoning, convulsions and severe bleeding. The Health Plan may determine that other similar acute conditions are or are not medical emergencies. The determination of covered benefits for services rendered in an emergency room is based on the Health Plan's review of a covered person's emergency room medical records, along with those relevant symptoms and circumstances which preceded the provision of care. The Health Plan must be notified following the onset of a medical emergency within 48 hours or within a reasonable time period as dictated by the circumstances.

OUTSIDE THE SERVICE AREA

A medical emergency outside the service area is defined as: the unexpected and immediately required care needed as a result of accidental injury or acute illness of such gravity that it is not medically feasible to bring the covered person to the primary care physician or a participating provider within the service area for treatment.

The covered person may be transported from outside the service area to the service area for continued medical management of an emergency condition at the option of the medical director or designee. The Health Plan will only exercise this option when the medical director or designee determines that such action will not have a detrimental effect on the covered person's medical condition.

The Health Plan must be notified of a medical emergency within 48 hours following its onset or within a reasonable time period as dictated by the circumstance. Each case outside the service area will be reviewed individually to determine whether the medical condition constituted a medical emergency.

COVERED PERSON COPAYMENTS

For certain services, the covered person is responsible for paying a portion of the cost of covered services. Usually, this portion is a flat dollar amount referred to as a copayment. The copayment requirements for this Health Plan are shown in the schedule of member copayments. The covered person may also call the Health Plan's customer service department for information on copayment amounts.

The total copayments the covered person is responsible for in any single calendar year shall not exceed \$1,500 for individual coverage and \$3,000 for family coverage. When the covered person has paid copayments that total the annual maximum, no further copayments shall be required by that covered person for the remainder of the calendar year. The covered person is responsible for providing documentation of the amount of copayments paid.

LIFETIME MAXIMUM COVERAGE LIMIT

There is no lifetime maximum coverage limit under this Health Plan.

COVERED BENEFITS SECTION

This chart provides a description of services and supplies covered by the HMO plan. However services and supplies not described here but mandated by state or federal law will be covered by the HMO plan.

The Health Plan pays the cost of covered care and medical supplies, less the copayment, as long as the care or supplies are: ordered by a covered provider; considered medically necessary for the covered person's treatment as a result of a covered accident, illness, condition or mental or nervous disorder; not specifically limited or excluded under this Health Plan; and rendered while this Health Plan is in force.

Types of Care	Special Limits/Circumstances
<p><i>Ambulance</i> Ambulance service to the nearest hospital Ambulance service to a covered person's home or skilled nursing facility Ambulance service from a hospital which is unable to provide proper care to the nearest hospital that can provide proper care</p>	<p><i>For services by boat, airplane or helicopter</i> When the pick-up point is inaccessible by ground transportation When the travel distance involved in getting the covered person to the nearest hospital that can provide proper care is too far for medical safety When speed in excess of ground vehicle speed is critical</p>
<p><i>Anesthesia Services</i></p>	<p>Both inpatient and outpatient</p>
<p><i>Cancer Services</i> Diagnosis and Treatment</p>	<p>Includes both inpatient and outpatient diagnostic tests and treatment except for experimental or investigational treatments</p>
<p><i>Cleft Lip and Cleft Palate</i></p> <ul style="list-style-type: none"> • Treatment and services for children under 18 years, including medical, dental, speech therapy, audiology and nutrition services only as specified by statute. 	
<p><i>Contraceptive Supplies</i></p> <ul style="list-style-type: none"> • Insertion and removal of IUD • Diaphragm • Insertion and removal of contraceptive implants • Contraceptive injections 	
<p><i>Cosmetic Surgery</i></p> <ul style="list-style-type: none"> • Plastic & reconstructive • Reduction mammoplasty 	<ul style="list-style-type: none"> • Repair or alleviation of damage if such treatment or surgery is the result of an accident. • For correction of a congenital anomaly for an eligible dependent. • Correction of an abnormal bodily function. • For an area of the body which was altered by the treatment of a disease. <p>All stages of reconstruction of a breast on which a mastectomy was performed in accordance with federal law. However, if there is no evidence of malignancy, such reconstruction and initial prosthetic device shall only be covered if received within two years after the date of the mastectomy.</p>

<p><i>Doctor's Care</i></p> <ul style="list-style-type: none"> • Office visits • Medical treatment in hospital or outpatient facility or surgery (other than office visit) includes anesthesia services; concurrent physician care (surgical assistance provided by another physician) and consultations • Child health supervision services • Adult preventive medical services • Allergy treatment – including testing, desensitization therapy and allergy immunotherapy, which includes hyposensitization serum when administered by a health care provider. • Diagnostic procedures, lab tests or x-rays, including their interpretation, for the treatment of a covered condition. 	<p><i>For Concurrent Physician Care and Consultations:</i></p> <p><i>For surgical assistance:</i></p> <ul style="list-style-type: none"> • The additional physician must actively participate in the treatment and: <ul style="list-style-type: none"> – the condition involves more than one body system or is so severe or complex that one physician cannot provide the care unassisted – the physicians have different specialties or have the same specialty with different sub-specialties and – must be authorized by the covered person's PCP or the Health Plan. <p><i>For Consultations:</i></p> <ul style="list-style-type: none"> • PCP must request the consultation • Consulting physician shall prepare a written report. <p><i>For child health supervision services:</i></p> <p>Medical services and supplies include: newborn's first examination in the hospital periodic examinations which shall include a history and physical examination, developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child oral and/or injectable immunizations laboratory tests normally performed for a well child evaluation and management counseling and/or risk factor reduction intervention for covered dependents without symptoms or established illnesses hearing screenings vision screenings</p> <p>These services shall conform with prevailing medical standards and shall not be less than 18 visits at approximately the following age intervals:</p> <ul style="list-style-type: none"> • birth • 2, 4, 6, 9, 12, 15 and 18 months • 2, 3, 4, 5, 6, 8, 10, 12, 14, and 16 years
	<p><i>Adult preventive medical services include:</i></p> <ul style="list-style-type: none"> • health history • laboratory tests (e.g. urinalysis, hemoglobin, and hematocrit, stool for occult blood, sexually transmitted diseases, etc.) • physical examination • vision - routine (eye chart), or refractive eye exams and hearing screenings • tuberculin skin test • routine male and female screening exams and tests (e.g. pap smear, pelvic exam, prostate gland screening) - limited to one exam per calendar year
<p><i>Durable Medical Equipment</i></p> <ul style="list-style-type: none"> • At the Health Plan's option, the rental or purchase of medical equipment and medical supplies for the care and treatment of a condition covered under this Health Plan, which includes: Trusses, braces, walkers, canes, crutches, casts and splints Occlusal guards, bite or dental splints, repositioning devices, and TMJ study models for the treatment of temporomandibular joint (TMJ) syndrome Commode chairs, bedpans/urinals, decubitus care equipment, and ostomy and urinary products Oxygen and rental of equipment for the 	<p><i>Durable Medical Equipment:</i></p> <p>Shall not serve as a comfort, hygiene, or convenience item. Shall not be used for the sole purpose of exercise. Shall not be used by any other party. Shall have been manufactured specifically for medical use. Shall not include shoe buildups, shoe orthotics, shoe braces or shoe supports unless the shoe is attached to a brace Shall not include water therapy devices, modifications to motor vehicles and/or homes or similar items</p>

<p>administration of oxygen, iron lung or other mechanical equipment for the treatment of respiratory paralysis</p> <p>Ambulatory home uterine activity monitoring devices (AHUM)</p> <p>Wheelchairs, hospital beds, lumbar-sacral- orthosis (LSO) and thoracic-lumbar-sacral- orthosis (TLSO) braces, and traction equipment</p> <p>Other medical equipment and supplies as determined to be medically necessary</p>	
<p>Eye Care</p> <ul style="list-style-type: none"> Routine or refractive eye examinations as part of the adult preventive medical care or child health supervision services benefit 	<p><i>For eyeglasses or contact lenses</i></p> <ul style="list-style-type: none"> Limited to the first pair following an accident to the eye or cataract surgery, including the examination for the prescription or fitting <p><i>For treatment of a covered condition:</i> Aphakic patients and soft lenses or sclera shells Following an injury, disease or accident.</p>
<p>Family Planning Services</p>	<p>Includes counseling and information on birth control, sex education and the prevention of sexually transmitted diseases.</p>
<p>Hemodialysis for Renal Disease</p>	<p>Includes equipment, training and medical supplies for home dialysis and dialysis centers.</p>
<p>Home Health Care</p> <p>Services by a home healthcare agency for a covered person confined and convalescing at home for a covered condition.</p> <p><i>Home health care services include:</i></p> <ul style="list-style-type: none"> Part-time, intermittent or continuous nursing care by registered nurses, or licensed practical nurses, nurse registries or home health agencies; Physical, speech, occupational and respiratory therapy; and infusion therapy Medical appliances, equipment, laboratory services, supplies, drugs, and medicines prescribed by the treating physician and other covered services provided by or for a home health agency, through a licensed nurse registry, or by an independent nurse licensed under chapter 464, Florida Statutes, to the extent that they would have been covered if the covered person had been confined in a hospital. 	<p><i>For approval of home health care services by your PCP or the Health Plan:</i></p> <ul style="list-style-type: none"> The treating physician must submit a home health care plan of treatment to your PCP. The plan of treatment must document that home health care is medically necessary and that the services are being provided in lieu of hospitalization or continued hospitalization; and Home health care benefits would be less costly than confinement to a hospital or skilled nursing facility. <p><i>Services which shall not be covered under this benefit include:</i></p> <ul style="list-style-type: none"> Any service that would not have been covered had the covered person been confined in a hospital. Services which are solely for the convenience of the covered person. Physical therapy is subject to outpatient limitations described under rehabilitative services (60 visits per injury)
<p>Hospice Care</p> <ul style="list-style-type: none"> In-home care <ul style="list-style-type: none"> –Physician services –Physical, respiratory, massage, speech and occupational therapy if approved by the Health Plan –Medical supplies, drugs and appliances –Home health aide services –Part-time or intermittent nursing care by a registered nurse (RN) or licensed practical nurse (LPN) or private duty nursing service –Oxygen –Infusion therapy Hospice inpatient care <ul style="list-style-type: none"> Room and board and general nursing care Inpatient care services same as inpatient hospital care 	<p><i>Hospice treatment program shall:</i></p> <p>Meet the standards outlined by the National Hospice Association;</p> <p>Be recognized as an approved hospice program by the Health Plan;</p> <p>Be licensed, certified, and registered as required by Florida law; and</p> <p>Be directed by the covered person’s PCP or the Health Plan 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.</p> <p><i>For hospice care:</i></p> <ul style="list-style-type: none"> Treatment for and counseling of terminally ill patients whose doctor has certified that they have less than one year to live

<p>Same covered services as in-home and outpatient hospice care Includes care for pain control or acute chronic symptom management</p> <ul style="list-style-type: none"> Hospice outpatient care Physician services Laboratory, x-ray, and diagnostic testing Ambulance service Same covered services as in-home hospice care 	<ul style="list-style-type: none"> Primary care physician (PCP) must submit a written hospice care plan or program; and PCP must submit a life expectancy certification. All hospice care expenses shall be approved in writing by the Health Plan While in the hospice program, regular plan benefits are not payable for expenses related to the terminal illness. <p><i>These following services are not covered under this Health Plan:</i></p> <ul style="list-style-type: none"> Social work services Bereavement and pastoral Financial Legal Dietary counseling Day care Homemaker and chore services Funeral services
<p><i>Hospital Inpatient Care</i></p> <ul style="list-style-type: none"> Hospital room, board and general nursing care for a semi-private room unless the Health Plan determines that a private room is medically necessary Room, board and treatment in an intensive, progressive, cardiac or neonatal care unit Other necessary services and supplies, for example: <ul style="list-style-type: none"> –use of operating room, labor room, delivery room and recovery room –use of covered drugs and medicines used by the patient –intravenous solutions, including glucose –dressings, ordinary casts, splints and trusses –anesthesia and related supplies –transfusion supplies and services including blood, blood plasma and serum albumin, if not replaced –respiratory therapy, including oxygen –diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing such as electrocardiograms and electroencephalograms –basal metabolism examinations –x-ray, including therapy –diathermy –all covered rehabilitative services 	<ul style="list-style-type: none"> Services and supplies must be furnished at a network hospital and must be authorized by the primary care physician or Health Plan in order to be covered. Exceptions to this include emergency services and other special circumstances, as approved by the Health Plan. Excludes services and supplies provided when the covered person is admitted to a hospital or other facility primarily to provide rehabilitative services.
<p><i>Immunizations</i></p>	<ul style="list-style-type: none"> Includes flu shots
<p><i>Mammograms</i> Breast cancer screening Diagnosis</p>	<p><i>For mammograms:</i> One baseline mammogram for women age 35 through 39 One mammogram every two years – ages 40 through 49 One mammogram every year – age 50 and over At any age if deemed medically necessary</p>
<p><i>Maternity Care</i></p> <ul style="list-style-type: none"> Pre-natal and post-natal care and monitoring of the mother Delivery in a hospital or birth center Postpartum care Newborn care and assessment, including initial exam from pediatrician Medically necessary clinical tests and immunizations 	<p><i>For maternity care:</i> Maternity care is not covered for dependent children who become pregnant, except for certain pregnancy complications and care of the newborn. (See page 25 for a definition of complications of pregnancy) Covered hospital stays for the mother and newborn child will be no less than 48 hours for a normal delivery 96 hours for a Cesarean-section delivery unless agreed</p>

<ul style="list-style-type: none"> • Routine well-baby nursery services • Midwife services 	to by the provider and the patient
<p><i>Mental Health, Alcoholism and Substance Abuse Care</i></p> <p>Inpatient – hospital, specialty institution, or residential facility</p> <p>Outpatient – alcoholism & substance abuse Treatment program must be accredited by the Joint Commission on Accreditation of Hospitals or approved by the state.</p> <p>Providers must be licensed in accordance with applicable law</p>	<p><i>For inpatient care:</i></p> <ul style="list-style-type: none"> • Alcoholism and substance abuse care is limited to a maximum of 31 days per calendar year total including detox. • Mental health and nervous disorders treatment is limited to a maximum of 31 days per calendar year total. <p><i>For outpatient care:</i></p> <ul style="list-style-type: none"> • Alcoholism and substance abuse care is limited to a maximum of 26 visits per calendar year total. • Mental health and nervous disorders treatment is limited to a maximum of 26 visits per calendar year total and includes diagnostic evaluation and psychiatric treatment, and individual and group therapy. • For learning and behavioral disabilities or mental retardation, coverage is limited to evaluation and diagnosis. • No coverage is provided for marriage counseling, court ordered care or testing or required as a condition of parole or probation, testing for aptitude, ability, intelligence or interest.
<p><i>Nutrition Counseling</i></p>	
<p><i>Nursing Services</i></p> <ul style="list-style-type: none"> • Nursing care by a registered nurse (RN) or licensed practical nurse (LPN) 	<p><i>For nursing care:</i></p> <p>Includes inpatient private duty nursing when authorized by the Health Plan</p> <p>Includes home health care services and hospice services</p>
<p><i>Oral Surgery</i></p> <ul style="list-style-type: none"> • Surgical treatment of non-dental injury to teeth, fractured or dislocated jaw, excision of tumors, cysts, abscesses and lesions of the mouth and surgical treatment of temporomandibular joint (TMJ) syndrome • Services related to an accident or injury occurring while, and as a result of, biting or chewing. 	
<p><i>Organ Transplants</i></p> <p>Services, care and treatment received for or in connection with the approved transplantation of the following human tissue and organs:</p> <ul style="list-style-type: none"> • Heart • Heart/lung • Lung • Liver • Kidney • Kidney/pancreas • Bone marrow • Cornea <p><i>Covered services include:</i></p> <p>Hospital and medical expenses in accordance with the same terms and conditions as the Health Plan shall pay benefits for care and treatment of any other covered condition; and</p> <p>Organ acquisition and donor costs. However, donor costs shall not be payable under this Health Plan if they are payable in whole or in part by any other insurance health plan, organization or person other</p>	<p><i>For organ transplants:</i></p> <p>Transplantation includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation.</p> <p><i>To have a transplant covered:</i></p> <ul style="list-style-type: none"> • Prior approval for the transplant must be obtained by the covered person's PCP from the Health Plan in advance of the covered person's initial evaluation for the procedure. • The Health Plan shall be given the opportunity to evaluate the clinical results of the evaluation. Such evaluation and approval shall be based on written criteria and procedures established by the Health Plan. • The facility in which the pre-transplant services, transplant procedure and post-discharge services will be performed must be licensed as a transplant facility and authorized by the Health Plan. <p><i>For bone marrow transplants:</i></p> <ul style="list-style-type: none"> • Includes the harvesting, transplantation and chemotherapy components. • Donor costs are covered in the same way as costs for the covered person, including limitations and non-

<p>than the donor's family or estate.</p>	<p>covered services.</p> <p><i>Transplant services shall not be covered when:</i></p> <ul style="list-style-type: none"> • 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; • The expense relates to the transplantation of any non-human organ or tissue; • The service or supply is in connection with the implant of an artificial organ, including the implant of the artificial organ; • The organ is sold rather than donated to the covered person; • The expense relates to the donation or acquisition of an organ for a recipient who is not covered by the Health Plan except in the case of the donor costs for bone marrow transplants; or • A denied transplant is performed; this includes follow-up care, immuno-suppressive drugs, and complications of such transplant. <p><i>The following services and supplies shall not be covered:</i></p> <p>Artificial heart devices used as a bridge to transplant; Drugs used in connection with diagnosis or treatment leading to a transplant when such drugs have not received FDA approval for such use; and Any service or supply in connection with identification of a donor from a local, state, or national listing.</p>
<p><i>Outpatient Care</i></p> <ul style="list-style-type: none"> • Treatment as an outpatient in a hospital, a health care provider's office, an ambulatory surgical center or other licensed outpatient healthcare facility • Clinical laboratory services • Services for outpatient surgery and outpatient treatment of an injury 	<p>Includes medically necessary supplies provided or used by the facility during the surgery or treatment, such as:</p> <ul style="list-style-type: none"> -use of operating room, and recovery room -use of covered drugs and medicines used by the patient -intravenous solutions, including glucose -dressings, ordinary casts, splints and trusses -anesthesia, related supplies and their administration -transfusion supplies and services including blood, blood plasma and serum albumin, if not replaced -respiratory therapy, including oxygen -diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing such as electrocardiograms and electroencephalograms -basal metabolism examinations -x-ray, including therapy -diathermy <p>services provided by a birthing center licensed pursuant to <i>section 383.30-383.335, Florida Statutes</i> other covered necessary services and supplies</p>
<p><i>Pathologist services</i></p>	<p>Both inpatient and outpatient</p>
<p><i>Pre-admission tests</i></p>	<ul style="list-style-type: none"> • Tests shall be ordered or authorized by the covered person's PCP; and • Tests shall be performed in a facility accepted by the hospital and the Health Plan in lieu of the same tests which would normally be done while hospital confined.
<p><i>Prostheses and Orthotic Devices</i></p> <ul style="list-style-type: none"> • Initial placement of the most cost effective prosthetic 	<p><i>For prostheses and orthotic devices:</i></p>

<p>or orthotic device, fitting, adjustments and repair.</p>	<ul style="list-style-type: none"> • Replacements covered if due to growth or change and approved by the Health Plan as medically necessary. • Shoe orthotics shall be covered only when attached to a brace.
<p><i>Radiologist Services</i></p>	<ul style="list-style-type: none"> • Both inpatient and outpatient
<p><i>Rehabilitative Services</i></p> <ul style="list-style-type: none"> • Spine and back disorder treatment • Manipulative services • Physical therapy • Speech therapy <p>ALL SERVICES SHALL BE PROVIDED BY LICENSED THERAPISTS, CHIROPRACTORS AND PHYSICIANS FOR THE PURPOSE OF AIDING IN THE RESTORATION OF NORMAL PHYSICAL FUNCTION.</p>	<p><i>For Rehabilitative Services</i></p> <ul style="list-style-type: none"> • Requires Health Plan approval of a written plan of treatment • Agreement that the covered person's condition should improve significantly within 60 days of the date therapy begins • Outpatient rehabilitative services limited to 60 visits per injury; inpatient rehabilitative services limited to the duration of hospital confinement <p>Rehabilitative services shall not be covered when:</p> <ul style="list-style-type: none"> • The covered person was admitted to a hospital or other facility primarily for the purpose of providing rehabilitative services; or • The services or supplies maintain rather than improve a level of physical function, or where it has been determined that the services shall not result in significant improvement in the covered person's condition within a 60 day period. • Other therapy types including recreational, educational, marital or sleep therapy.
<p><i>Respiratory Therapy</i></p> <ul style="list-style-type: none"> • Services of respiratory or inhalation therapists • Oxygen 	<p>Inpatient or outpatient basis</p>
<p><i>Second Medical Opinions</i></p> <p>May be requested by the covered person or the Health Plan for:</p> <ul style="list-style-type: none"> • Elective surgery • When the appropriateness or necessity of a covered surgical procedure is questioned • Serious injury or illness 	<p>The covered person:</p> <ul style="list-style-type: none"> • Must provide prior notice to the Health Plan. <p>May obtain the opinion from <u>any</u> licensed physician within the Health Plan's service area. The use of second medical opinions in connection with a particular diagnosis or treatment may be restricted to a maximum of three per calendar year.</p> <p>All necessary tests for the second medical opinion may be conducted by participating providers.</p> <p>The Health Plan shall review the second medical opinion, once rendered, and determine the treatment obligations of the Health Plan. That judgment shall be controlling. Any treatment obtained that is not authorized by the Health Plan shall be at the covered person's expense.</p> <p>Covered expenses for the second opinion:</p> <ul style="list-style-type: none"> • If a participating physician is selected, the only cost to the covered person will be the applicable copayment. • If a non-participating physician is selected, the Health Plan shall pay 60 percent of the usual and customary charges for those services in the community in which they were rendered as determined by the Health Plan and the covered person shall be responsible for the remainder of the fee.
<p><i>Skilled Nursing Facility Care</i></p> <ul style="list-style-type: none"> • Room, board and general nursing care • Services and supplies for necessary treatment 	<p><i>For skilled nursing facility care:</i></p> <p>PCP or Health Plan approval of a written plan of treatment. Patient must require skilled care for a condition (or a related condition) which was treated in the hospital and such care can be provided at a skilled nursing facility in lieu of hospitalization or continued hospitalization.</p> <p>Patient shall be admitted to the facility immediately following</p>

	<p>discharge from the hospital. Skilled nursing care or services are provided on a daily basis Limited to 60 days of confinement per calendar year. Services shall be ordered by and provided under the direction of a physician.</p>
<i>Surgical Procedures</i>	Inpatient or outpatient basis
<i>Surgical Sterilization</i>	<ul style="list-style-type: none"> Limited to tubal ligations and vasectomies.

Pregnancy Complications and Care of the Newborn

Maternity care in connection with the pregnancy of eligible children due to the following complications of pregnancy are covered by the Health Plan:

- Conditions whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy;
- Conditions that are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity;
- a non-elective cesarean section;
- an ectopic pregnancy which is terminated; and
- a spontaneous termination of pregnancy, which occurs before the twenty-second (22nd) week of gestation.

NOTE: Complications of pregnancy do not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy which do not constitute a nosologically distinct complication of pregnancy.

Newborn Care

Coverage for the newborn child of an eligible dependent will be terminated 18 months after the birth of the newborn.

This coverage shall include:

- coverage for injury or sickness, including medically necessary care or treatment for medically diagnosed congenital defects, birth abnormalities, or prematurity,
- the transportation costs of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition. Such transportation shall be certified by the attending physician as necessary to protect the health and safety of the newborn child.

Coverage for the newborn child of a mother who does not convert to family coverage within the prescribed time period is limited to well-baby hospital nursery services.

PRESCRIPTION DRUGS

When a participating provider prescribes a drug, you may have your prescription filled at any of the Health Plan's participating pharmacies, a list of which are included in the Health Plan's Provider Directory. Mail-order Prescription Drug coverage includes up to a 90-day supply of a routine maintenance medication for the listed copayment. Prescription drugs are subject to the Health Plan's preferred drug list and the provisions noted below.

The prescription drug copayments for generic and brand name are shown in the schedule of member copayments. The covered person's ID card shall be presented and the copayment shall be paid to the participating pharmacy each time a prescription is filled or refilled.

In addition to the higher brand name copayment, the covered person shall pay the pharmacist 100 percent of the difference between the generic and the brand name prescription drug when it is dispensed at the request of the covered person if a generic is available. If the prescribing physician or other participating provider authorized to prescribe drugs within the scope of his or her license indicates on the prescription "brand name medically necessary" or "dispense as written" for a drug for which there is a generic equivalent, the brand name drug shall be dispensed for the brand name copayment only. However, the Florida Boards of Medicine and Pharmacy, pursuant to chapter 465, Florida Statutes, have established a negative drug formulary. No drug substitution shall be allowed for the following:

- | | |
|---|--------------------------------------|
| 1. Digitoxin | 5. Theophylline (controlled release) |
| 2. Conjugated estrogen | 6. Levothyroxine sodium |
| 3. Dicumarol | 7. Pancrelipase (oral dosage forms) |
| 4. Chlorpromazine (solid oral dosage forms) | |

DRUGS THAT ARE COVERED BY THE PLAN

Covered drugs shall include:

- Insulin
- Needles and syringes with insulin
- FDA-approved glucose strips and tablets
- Prepackaged items, such as insulin with needles or syringes, dispensed for the number of days' usage prescribed, or package quantity, whichever is greater
- Prescription refills once a usage percentage of the previous prescription, as established by the Health Plan, has been met based on the dosage schedule prescribed by the physician or other participating provider.

DRUGS THAT ARE NOT COVERED BY THE PLAN

- Any drug, medicine or medication that is consumed at the place where the prescription is given (provider's office or health care facility)
- Any drug, medicine or medication that is dispensed by a physician or other participating provider (other than a pharmacy)
- Prescription refills in excess of the number specified by the physician or dispensed more than one year from the date of the physician's or other participating provider authorized to prescribe drugs within the scope of his or her license original order;
- The administration of covered medication;
- Prescriptions that are to be taken by or administered to the covered person, in whole or in part, while he or she is a patient in a hospital, skilled nursing facility, convalescent hospital, inpatient hospice facility, or other facility where drugs are ordinarily provided by the facility on an inpatient basis;
- Medication that is covered by Worker's Compensation or Occupational Disease Laws or by any state or governmental agency;
- Prescriptions ordered or received in excess of any maximums covered under this benefit, and not covered under any other provision in this Health Plan;
- Any drug, medicine or medication labeled "Caution-Limited by Federal Law to Investigational Use." Any experimental drug or drug used for non-FDA approved indication or prescribed for use by a route of administration that is not approved by the FDA even though a charge is made to the covered person;
- Immunizing agents,
- Non federal legend or over-the-counter drugs;
- Devices or appliances, including, but not limited to, hypodermic needles/syringes (exception: those items associated with an insulin prescription or prepackaged with other medications), support garments, and other non-medical substances, regardless of intended use;
- Retin-A for cosmetic purposes;
- Anti-obesity drugs;
- Nicorette and similar drugs to deter smoking;
- Amphetamines and/or anorexiant for weight loss;
- Hormone treatment in preparation for sexual reassignment;
- Any costs related to the mailing, sending or delivery of prescription drugs; and
- Prescriptions filled at a non-participating pharmacy, except for prescriptions required during emergency care.

EXCLUSIONS AND LIMITATIONS

FOLLOWING COVERAGE ACCESS RULES

If you do not follow the coverage access rules described in this document, you risk having services and supplies received not covered by the Health Plan. In such a circumstance, you would be responsible for reimbursing the Health Plan.

Also, covered persons shall understand that the ordering of a service by a physician does not in itself make such service medically necessary or a covered service.

Services Not Covered By The Plan

The following services and supplies are excluded from coverage under this Health Plan unless a specific exception is noted. Exclusions may be subject to certain coverage limitations:

Abortion: elective abortions performed at any time during a pregnancy; or services in connection with the pregnancy of eligible children; however, medically necessary services due to the following complications of pregnancy are covered by the Health Plan:

1. Conditions whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy;
2. Conditions that are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity;
3. a non-elective cesarean section;
4. an ectopic pregnancy which is terminated; and
5. a spontaneous termination of pregnancy, which occurs before the twenty-second (22nd) week of gestation.

NOTE: Complications of pregnancy do not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy which do not constitute a nosologically distinct complication of pregnancy.

Acupuncture services.

Arch supports, orthopedic shoes, sneakers, or support hose, or similar type devices/appliances regardless of intended use.

Autopsy or postmortem examination services, unless specifically requested by the Health Plan.

Biofeedback services, and other forms of self-care or self-help training and any related diagnostic testing, hypnosis, meditation, mind expansion, elective psychotherapy such as Gestalt therapy, transactional analysis, transcendental meditation, Z-therapy, and Erhard seminar training (EST).

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., services or supplies to treat a complication of cosmetic surgery shall not be covered under this Health Plan).

Cosmetic surgery (plastic and reconstructive surgery), and any other service and supply to improve the covered person's appearance or self-perception, such as electrolysis, procedures or supplies to correct baldness, or the appearance of skin (wrinkling).

Costs incurred by the Health Plan, related to:

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; and
2. Telephone consultations, failure to keep a scheduled appointment, or completion of any form and/or medical information.

Custodial care, including any service or supply of a custodial nature primarily intended to assist the covered person in the activities of daily living. This includes rest homes (facilities), nursing homes, skilled nursing facility, home health aides (sitters), home mothers, domestic maid services, and respite care.

Dental care or any treatment relating to the teeth, jaws, or adjacent structures (e.g., periodontium), including but not limited to: extraction or cleaning of the teeth; implant, braces, crowns, bridges, fillings, dentures, x-rays, periodontal, orthodontic, or orthognathic treatment; rapid palatal expanders; continuous passive motion (CPM) devices.

Dietary regimens, treatments, food, food substitutes, vitamins or exercise programs for reducing or controlling weight.

Durable medical equipment, other than the equipment specifically listed in the covered benefits section. This exclusion includes, but is not limited to, modifications to motor vehicles and or homes such as wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs or whirlpools and exercise equipment.

Educational therapy.

Exercise programs, including cardiac rehabilitation exercise programs, or visits for the purpose of exercise by bicycle ergometer or treadmill. These programs or visits are excluded even if the purpose is to determine the feasibility of an exercise program.

Experimental or investigational treatment, as defined in the glossary.

Eye care, including:

1. The purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically provided for in the covered benefits section;
2. Radial keratotomy, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error; and
3. Training or orthoptics, including eye exercises.

Foot care (routine), including any service or supply in connection with foot care in the absence of disease, injury or accident. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, removal of warts, corns, or calluses, or trimming of toenails, unless determined by the Health Plan to be medically necessary.

Hearing aids, (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers; however, hearing tests shall be a covered service when associated with covered ear surgery.

Hypnotism, medical hypnotherapy or hypnotic anesthesia.

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

Infertility treatment and supplies, including infertility testing, treatment of infertility, diagnostic procedures and artificial insemination, to determine or correct the cause or reason for infertility or inability to achieve conception. This includes artificial insemination, in-vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures.

Marital therapy.

Massage therapy.

Military service-connected medical care, for which the covered person is legally entitled to service from military or government facilities, and for which such facilities are reasonably accessible to the covered person.

Non-prescription drugs and supplies, including any non-prescription medicine, remedy, biological product, pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, health foods, or blood pressure kits except as specifically provided for in the covered benefits section under prescription drugs.

Obesity and weight reduction treatment, including surgical operations and medical procedures for the treatment of morbid obesity, unless determined to be medically necessary by the Health Plan such as intestinal or stomach by-pass surgery and a weight loss program required by the covered person's primary care physician prior to surgery.

Occupational therapy, unless provided as a home health care service or hospice service.

Orthomolecular therapy, including nutrients, vitamins, and food supplements.

Personal comfort, hygiene or convenience items, including services and supplies deemed to be not medically necessary by the Health Plan and not directly related to the care of the covered person, including, but not limited to,

beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than medically necessary ambulance services that are specifically provided for in the covered benefits section, motel/hotel accommodations, air conditioners, humidifiers, dehumidifiers, air purifiers or filters, or physical fitness equipment.

Recreational therapy.

Reversal of voluntary, surgically-induced sterility, including the reversal of tubal ligations and vasectomies.

Services or supplies, that are:

1. Determined not to be medically necessary;
2. Not specifically listed in the covered benefits section unless such services are specifically required to be covered by state or federal law. This Health Plan shall provide coverage on a primary or secondary basis as required by state or federal law;
3. Court ordered care or treatment, unless otherwise covered in this Health Plan;
4. 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 commission of a crime punishable as a felony;
 - c. Engaging in an illegal occupation;
 - d. Services in the armed forces; or
 - e. Intentionally self-inflicted injuries, suicide or attempted suicide, without regard to the mental state of the covered person.
5. Received prior to a covered person's effective date or received on or after the date a covered person's coverage terminates under this Health Plan, unless coverage is extended in accordance with the extension of benefits provision in the administrative provisions section;
6. Provided by a physician or other health care provider who normally resides in the covered person's home;
7. 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;
8. Non-medical conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change;
9. Supplied at no charge; or
10. Determined by the Health Plan not to be the most cost-effective setting, procedure, or treatment.

Sexual reassignment, reproduction or modification services, including hormone therapy, intersex surgery, sexual deviations and disorders, psychosexual dysfunctions, testicular prosthesis, genetic tests to determine paternity or sex of a child, or the insertion of penile prosthesis except when necessary in the treatment of organic impotence resulting from diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, postprostatectomy, postpriapism, and epispaidas and exstrophy.

Sleep therapy.

Smoking cessation programs, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco, including but not limited to nicotine withdrawal programs and Nicorette gum or patch.

Training and educational programs, including programs primarily for pain management, or vocational rehabilitation unless specifically provided by law.

Transfusion, autologous.

Transportation services, that is non-emergency transportation between institutional care facilities, or to and from the covered person's residence.

Volunteer services, or services which would normally be provided free of charge to a covered person.

Weight control/loss programs, including but not limited to, food supplements, appetite suppressants, dietary regimens or treatments, exercise programs, or equipment.

Wigs.

Work related condition services, to the extent the covered person is covered or required to be covered by a workers' compensation law. If the covered person enters into a settlement giving up rights to recover past or future medical benefits under a workers' compensation law, this Health Plan shall not cover past or future medical services that are the subject of or related to that settlement. In addition, if the covered person is covered by a workers' compensation program that limits benefits if other than specified health care providers are used and the covered person receives care or services from a health care provider not specified by the program, this Health Plan shall not cover the balance of any costs remaining after the program has paid.

GLOSSARY

ACCIDENT shall mean accidental bodily injury sustained by the covered person which results in and is the direct cause of medical expenses independent of illness.

ACCIDENTAL DENTAL INJURY shall mean an injury to the mouth or structures within the oral cavity, including teeth, caused by a sudden unintentional, and unexpected event or force. It shall include injuries caused by biting or chewing.

ADVERSE BENEFIT DETERMINATION means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in the Health Plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) of, a benefit resulting from the application of any Utilization Management Program, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary.

AMBULANCE shall mean any private or publicly owned land, air, or water vehicle licensed pursuant to chapter 401, part III, Florida Statutes, or for services rendered outside Florida other states' applicable laws, that is designed, constructed, reconstructed, maintained, equipped, or operated for, and is used for, or intended to be used for, air, land, or water transportation of persons who are in need of medical or surgical attention.

AMBULATORY SURGICAL CENTER shall mean a facility licensed pursuant to chapter 395, Florida Statutes, or for services rendered outside Florida other states' applicable laws, 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. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center.

BIRTH CENTER shall mean any facility, institution, or place, licensed pursuant to chapter 383, Florida Statutes, or for services rendered outside Florida other states' applicable laws, which is not an ambulatory surgical center or a hospital or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low risk pregnancy.

CALENDAR YEAR shall mean a period of one year which starts on January 1 and ends December 31.

CLAIM means a request for benefits under the Health Plan made by a Member in accordance with the Health Plan's procedures for filing benefit claims, including Pre-Service Claims and Post-Service Claims.

CLAIMANT means a Member or a Member's authorized representative acting on behalf of the Member. The Health Plan may establish procedures for determining whether an individual is authorized to act on behalf of the Member. If the Claim is an Urgent Care Claim, a Health Care Professional, with knowledge of the Member's medical condition, shall be permitted to act as the Member's authorized representative.

CONCURRENT CARE means an ongoing course of treatment to be provided over a period of time or number of treatments that AvMed previously approved.

CONDITION shall mean any disease, illness, injury, bodily dysfunction, pregnancy, or mental or nervous disorder of a covered person. For any preventive care benefits provided in this Health Plan, condition shall include the prevention of sickness.

CONFINEMENT shall mean an approved medically necessary covered stay as an inpatient in a hospital that is:

1. Due to a 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 shall mean those amounts payable by the covered person, at the time of service, as specifically set forth in the schedule of member copayments. The copayment shall be expressed as a dollar amount.

COVERED PERSON shall mean eligible employees, retirees, surviving spouses, COBRA participants, or any eligible dependents included for coverage under this Health Plan. Eligibility requirements are specified in the administrative provisions section.

COVERED SERVICES OR SUPPLIES shall mean any of the following:

1. Medical services, supplies or equipment which are medically necessary and not otherwise excluded by the Health Plan; and
2. Child health supervision services (well child care).

The Division for State Group Insurance shall have sole discretion to determine if a service or supply is covered, limited, or excluded by the Health Plan.

CUSTODIAL CARE shall mean care which shall not require skilled nursing care or rehabilitation services and is designed solely to assist the covered person with the activities of daily living, such as: help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine.

ELECTIVE ADMISSION shall mean a hospital admission which is not of an urgent or emergency nature and can be scheduled in advance and at a time which is convenient for the covered person and the covered person's physician without risking the covered person's well being.

ELECTIVE SURGERY shall mean surgery of a non-emergency nature in which the covered person can elect when, or if, surgery can be done.

EXPERIMENTAL OR INVESTIGATIONAL TREATMENT shall mean 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 by the Agency for Health Care Administration:

1. Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or other appropriate government entity and approval for marketing has not, in fact, been given at the time such is furnished to the covered person;
2. 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;
3. Reliable evidence 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;
4. Such 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;
5. There is no consensus among practicing physicians that the treatment, therapy or device is safe or effective for the treatment in question; or
6. 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 shall mean:

1. Reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;
2. 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;
3. 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;
4. 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
5. The records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy or device for the condition in question.

FULL-TIME POSITION shall mean any position authorized for the normally established work period, either daily, weekly, monthly, or annually; however, in no case shall such full-time position involve less than eight months during any 12-month period.

GROUP EFFECTIVE DATE shall mean the effective date of the contract with the Health Plan.

HEALTH CARE PROFESSIONAL means a Physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

HEALTH CARE PROVIDER OR PROVIDERS shall mean comprehensive outpatient rehabilitative facilities, dialysis centers, durable medical equipment suppliers, and the following health care professionals and facilities licensed pursuant to the noted chapter in Florida Statutes, or for services rendered outside Florida other states' applicable laws: advanced registered nurse practitioners (464), ambulance (401), ambulatory surgical centers (395), anesthesiologists (458), audiologists (468), birthing centers (383), certified nurse midwives (464), certified registered nurse anesthetists (464), chiropractors (460), clinical laboratories (483), clinical social workers (491), dentists (466), home health agencies (400), hospice (400), hospitals (395), lithotripsy facilities (395), marriage and family therapists (491), mental health counselors (491), midwives (467), nurse clinicians (464), nurse practitioners (464), nurses (464), opticians (484), optometrists (463), oral surgeons (458), osteopaths (459), pharmacies (465), pharmacists (465), physical therapists (486), physicians (458), physician assistants (458, 459, 460), podiatrists (461), psychologists (490), rehabilitation facilities (395), residential treatment facilities (394), respiratory therapists (468), skilled nursing facilities (400), speech-language pathologists (468), specialty facilities (394), substance abuse facilities (394).

HOME HEALTH AIDE shall mean a person certified by an accredited junior college or vocational technical school as having completed an approved course of study.

HOME HEALTH AGENCY shall mean an institution or agency licensed pursuant to chapter 408, part IV, Florida Statutes, or for services rendered outside Florida other states' applicable laws, which provides approved services for people who are confined and convalescing at home in lieu of the hospital. A home health agency may operate independently or as part of a hospital.

HOSPICE shall mean an autonomous, centrally administered, nurse-coordinated program licensed pursuant to chapter 400, part VI, Florida Statutes, or for services rendered outside Florida other states' applicable laws, which provides a continuum of home, outpatient and inpatient care for a terminally ill covered person and members of the covered person's family. It employs an inter-disciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

HOSPITAL shall mean a facility licensed pursuant to chapter 395, Florida Statutes, or for services rendered outside Florida other states' applicable laws, engaged in providing medical care and treatment to a patient as a result of illness, accident or mental or nervous disorder on an inpatient or outpatient basis at the patient's expense and which fully meets all the following tests:

1. It is a hospital accredited by the Joint Commission on the Accreditation of Hospitals or the American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities;
2. It maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of patients under the supervision of a staff of fully licensed physicians. However, no claim for payment of treatment, care or services

shall be denied because a hospital lacks major surgical facilities or is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability; and

3. It continuously provides 24 hours a day nursing service by or under the supervision of registered graduate nurses.

The term hospital shall not include a specialty or residential facility; nor shall it include a U.S. Government hospital or any other hospital operated by a governmental unit, unless a charge is made by such hospital that the patient is legally required to pay without regard to the existence of insurance.

ILLNESS shall mean physical sickness or disease, pregnancy, bodily injury, or congenital anomaly.

INJURY shall mean an accidental bodily harm that:

1. Is caused by a sudden and unexpected event or force;
2. Is sustained while the covered person's coverage is in force; and
3. Results in and is the direct cause of medical expenses independent of illness.

INPATIENT shall mean a covered person who has been admitted upon the orders of a physician as a bed patient for medically necessary services and/or treatment in a hospital or other covered facility.

INTENSIVE CARE UNIT shall mean a specialized area in a hospital where an acutely ill, medical or surgical inpatient receives intensive care or treatment. Included in the hospital's charge for such units are the services of specially trained professional staff and nurses, supplies, the use of any and all equipment and the patient's board. When utilized, a coronary care unit shall also be defined as an intensive care unit.

INTER-DISCIPLINARY TEAM shall mean the working unit composed by the integration of the various helping professionals and lay persons providing hospice care. Such team shall, at a minimum, consist of a physician licensed pursuant to chapter 458 or 459, Florida Statutes, or for services rendered outside Florida other states' applicable laws, a nurse licensed pursuant to chapter 464, Florida Statutes, or for services rendered outside Florida other states' applicable laws, a social worker licensed pursuant to chapter 491, Florida Statutes, or for services rendered outside Florida other states' applicable laws, a member of the clergy or counselor, and volunteers. Such team shall be primarily concerned with controlling the physical, sociological and psychological symptoms of degenerative disease.

MANIPULATIVE SERVICES shall mean a term of physical medicine involving the skillful and trained use of the hands to treat diseases or symptoms resulting from misalignment of the spine. Manipulative services do not include massage therapy.

MEDICAL SUPPLIES OR EQUIPMENT shall mean supplies or equipment that shall be:

1. Ordered by a physician;
2. Of no further use when medical need ends;
3. Usable only by the covered person;
4. Not primarily for the covered person's comfort or hygiene;
5. Not for environmental control;
6. Not for exercise; and
7. Manufactured specifically for medical use.

MEDICALLY NECESSARY shall mean the covered services and supplies required to identify or treat the illness, injury or mental or nervous disorder which a physician has diagnosed or reasonably suspects. The service must:

1. Be consistent with the symptom, diagnosis and treatment of the patient's condition;
2. Be in accordance with standards of good medical practice;
3. Be required for reasons other than convenience of the patient or his/her physician;
4. Be approved by the appropriate medical body or board for the illness or injury in question; and
5. Be the most appropriate, efficient and economical medical supply, service, or level of care which can be safely provided.

The fact that a service is prescribed by a physician does not necessarily mean that such service is medically necessary or a covered service.

MEDICARE shall mean the health insurance programs under Title XVIII of the United States Social Security Act of 1965, as then constituted or as later amended.

MEDICARE I shall mean individual coverage for retirees or surviving spouses who are eligible for Medicare.

MEDICARE II shall mean family coverage for retirees or surviving spouses with one or more eligible dependents where at least one, but not all, covered persons are eligible for Medicare.

MEDICARE III shall mean family coverage for retirees and their spouses only, both of whom are eligible for Medicare.

MENTAL AND NERVOUS DISORDER shall mean any and all disorders set forth in the diagnostic categories of the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder. Examples shall include, but are not limited to, attention deficit hyperactivity, bulimia, anorexia-nervosa, bipolar affective disorder, autism, schizophrenia, anxiety, depression, and Tourette's disorder.

MENTAL HEALTH PROVIDERS shall mean psychiatrists licensed pursuant to chapter 458 and 459, Florida Statutes, or for services rendered outside Florida other states' applicable laws; psychologists licensed pursuant to chapter 490, Florida Statutes, or for services rendered outside Florida other states' applicable laws; clinical social workers, marriage and family therapists, and mental health counselors licensed pursuant to chapter 491, Florida Statutes, or for services rendered outside Florida other states' applicable laws; medical doctors licensed pursuant to chapter 458, Florida Statutes, or for services rendered outside Florida other states' applicable laws; and doctors of osteopathy licensed pursuant to chapter 459, Florida Statutes, or for services rendered outside Florida other states' applicable laws.

MIDWIFE shall mean a person licensed pursuant to chapter 467, Florida Statutes, or for services rendered outside Florida other states' applicable laws, to practice midwifery including a certified nurse midwife licensed pursuant to chapter 464, Florida Statutes, or for services rendered outside Florida other states' applicable laws.

NON-PARTICIPATING HOSPITAL shall mean a hospital which has not entered into a contractual agreement with the Health Plan to provide services to covered persons.

NON-PARTICIPATING PHARMACY shall mean a pharmacy that has not entered into a contractual agreement with the Health Plan to provide services to covered persons.

NON-PARTICIPATING PHYSICIAN shall mean a physician who has not entered into a contractual agreement with the Health Plan to provide services to covered persons.

NON-PARTICIPATING PROVIDER shall mean a hospital, a physician, or a health care provider who has not entered into a contractual agreement with the Health Plan to provide services to covered persons.

NURSING SERVICES shall mean services that are provided by an advanced registered nurse practitioner (A.R.N.P.), registered nurse (R.N.), or a licensed practical nurse (L.P.N.), who is licensed pursuant to chapter 464, Florida Statutes and:

1. Acting within the scope of that person's license; or
2. Authorized by a physician; and
3. Not a member of the covered person's immediate family.

OUTPATIENT shall mean a patient who is receiving medically necessary care or treatment ordered by a physician and who is not an inpatient.

OUTPATIENT HEALTH CARE FACILITY shall mean a licensed facility other than a physician's, physical therapist's, or midwife's office, which is engaged in providing medically necessary outpatient services for the treatment of a covered illness or accident.

PALLIATIVE CARE shall mean the reduction or abatement of pain and other troubling symptoms by appropriate coordination of all elements of the inter-disciplinary team required to achieve needed relief of distress.

PARTICIPATING HOSPITAL shall mean a hospital which has entered into a contractual agreement with the Health Plan to provide services to covered persons at a negotiated rate.

PARTICIPATING PHARMACY shall mean a pharmacy which has entered into a contractual agreement with the Health Plan to provide services to covered persons at a negotiated rate.

PARTICIPATING PHYSICIAN shall mean a physician who has entered into a contractual agreement with the Health Plan to provide services to covered persons at a negotiated rate.

PARTICIPATING PROVIDER shall mean a hospital, a physician, or a health care provider who has entered into a contractual agreement with the Health Plan to provide services to covered persons at a negotiated rate.

PART-TIME POSITION shall mean any position authorized for less than the entire normally established work period, either daily, weekly, monthly, or annually.

PHARMACIST shall mean a person who is licensed pursuant to chapter 465, Florida Statutes, or for services rendered outside Florida other states' applicable laws, to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

PHARMACY shall mean an establishment licensed pursuant to chapter 465, Florida Statutes, or for services rendered outside Florida other states' applicable laws, where prescription medications are dispensed by a pharmacist.

PHYSICAL THERAPIST shall mean a person who is duly registered or licensed pursuant to chapter 486, Florida Statutes, or for services rendered outside Florida other states' applicable laws, to engage in physical therapy practice.

PHYSICIAN shall mean a person properly licensed to practice medicine pursuant to Florida Statutes, as noted, or for services rendered outside Florida other states' applicable laws, including:

1. A doctor of medicine (458) or doctor of osteopathy (459);
2. A licensed dentist (466) who performs specific surgical or non-dental procedures covered by the Health Plan, or who renders services due to injuries resulting from accidents, provided such procedures or services are within the scope of the dentist's professional license;
3. A licensed optometrist (463) who performs procedures covered by the Health Plan provided such procedures are within the scope of the optometrist's professional license;
4. A licensed podiatrist (461) who performs procedures covered by the Health Plan provided such procedures are within the scope of the podiatrist's professional license;
5. A licensed psychologist (section 490.003(3)) when providing a medically necessary covered service; or
6. A licensed chiropractor (460) who performs procedures covered by the Health Plan provided such procedures are within the scope of the chiropractor's professional license.

PLAN shall mean the State of Florida Employees' Group Insurance Program.

POLICY shall mean the written document which describes the covered benefits provided under the State of Florida Employees' Group Insurance Program.

POST-SERVICE CLAIM means any Claim for benefits under the Health Plan that is not a Pre-Service Claim.

PRESCRIPTION shall mean a direct order for the preparation of a medication for the benefit of and use by a covered person. This order may be given to the pharmacist verbally or in writing by the physician or other participating provider authorized to prescribe drugs within the scope of his or her license. The medication shall be obtainable only by prescription.

PRESCRIPTION DRUGS shall mean drugs and medicines requiring a written prescription for drugs approved by the United States Food and Drug Administration and dispensed by a licensed pharmacist. Over-the-counter drugs, investigational or experimental drugs, oral contraceptives for contraception, drugs used for cosmetic purposes, Nicorette and similar drugs used to deter smoking are not included for coverage even though a physician or other participating provider authorized to prescribe drugs within the scope of his or her license may write a prescription for such.

PRE-SERVICE CLAIM means any Claim for benefits under the Health Plan with respect to which, in whole or in part, a Member must obtain authorization from AvMed in advance of such services being provided to or received by the Member.

PRIMARY CARE PHYSICIAN shall mean a participating physician who has been chosen by the covered person to be responsible for providing, prescribing, directing, and authorizing all care and treatment of the covered person.

PRIVATE ROOM shall mean a hospital room with one bed accommodation in which an inpatient receives board and general nursing care included in the hospital's charge for such room.

PROGRESSIVE CARE UNIT shall mean a specialized area in a hospital furnished with appropriate equipment for monitoring and medically supervising inpatients who are no longer considered to be critical or require intensive care or treatment but who have not improved enough to be returned to a routine hospital care environment.

PSYCHIATRIC FACILITY shall mean a facility licensed pursuant to chapter 394, Florida Statutes, or for services rendered outside Florida other states' applicable laws, to provide for the medically necessary care and treatment of mental and nervous disorders. For the purposes of this Health Plan, a psychiatric facility is not a hospital, as defined in this Health Plan.

RELEVANT DOCUMENT means any documentation that:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the determination;
3. Demonstrates compliance with the administrative process; and
4. Constitutes a statement of policy or guidance with respect to the Health Plan concerning the Adverse Benefit Determination for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the Adverse Benefit Determination.

SEMI-PRIVATE ROOM shall mean a hospital room with two bed accommodations in which an inpatient receives board and general nursing care included in the hospital's charge for such room.

SERVICE AREA shall mean the geographic area shown in the service area attachment to this Health Plan, and as approved by the Office of Insurance Regulation of the state in which this Health Plan is delivered, if such approval is required.

SICKNESS shall mean a bodily disease for which expenses are incurred while coverage under this Health Plan is in force.

SKILLED NURSING CARE shall mean care which is furnished by, or under the direct supervision of, licensed registered graduate nurses (under the general direction of the physician) to achieve the medically desired result and to ensure the covered person's safety. Skilled nursing care may be the rendering of direct care, when the ability to provide the service requires specialized (professional) training; or observation and assessment of the covered person's medical needs; or supervision of a medical treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired medical results.

SKILLED NURSING FACILITY shall mean an institution licensed pursuant to chapter 400, part I, Florida Statutes, or for services rendered outside Florida other states' applicable laws, or a distinct part of a hospital, primarily engaged in providing the following to inpatients:

1. The treatment shall be given by or under the supervision of a physician;
2. Skilled nursing services shall be given by or under the supervision of a licensed registered graduate nurse;
3. Rehabilitative services shall be given by or under the supervision of licensed physical therapists;
4. It shall 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; and
5. Other medically necessary related covered health services.

SPECIALTY INSTITUTION OR RESIDENTIAL FACILITY shall mean a facility licensed pursuant to chapter 394, Florida Statutes, or for services rendered outside Florida other states' applicable laws, which provides an inpatient rehabilitation program for the treatment of persons suffering from alcohol or drug abuse or mental or nervous conditions. Such program shall be accredited by the Joint Commission of the Accreditation of Hospitals (JCAH) and approved by the Department of Health and Rehabilitative Services.

STATE shall mean the state of Florida.

STATE OFFICER shall mean any constitutional state officer, any elected state officer paid by state warrant, or any appointed state officer who is commissioned by the Governor and who is paid by state warrant.

TERMINALLY ILL shall mean a medical prognosis of limited expected survival of one year or less at the time of referral to a hospice program, of a covered person with a chronic, progressive illness which has been designated not curable by the covered person's attending physician.

TREATING PHYSICIAN shall mean the physician responsible for providing primary or specialty care to a covered person on an inpatient or outpatient basis.

URGENT CARE CLAIM means any Claim for medical care or treatment that could seriously jeopardize the Member's life or health or the Member's ability to regain maximum function or, in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment requested. Generally, the determination of whether a Claim is an Urgent Care Claim shall be made by an individual acting on behalf of the Health Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician with knowledge of the Member's medical condition determines that the Claim is an Urgent Care Claim, it shall be deemed as such.

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