

VISTA HEALTHPLAN™, INC.

Policy for

Health Maintenance Organizations

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

Effective 1/1/2006

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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 their personnel office 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 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 days later. If the employee is a state officer, such officer may enroll within 60 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, 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.

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 31 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.

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 shall be notified, in writing, within 31 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 31 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 while a covered person is totally disabled, the benefits described in the covered benefits section shall be provided for the sickness or injury which caused such continuous total disability. This extension of benefits shall cease on the earliest of:

1. The date on which the continuous total disability ceases, but in no case longer than 12 months;
2. The end of the 12 month period immediately following the termination date of this Health Plan's contract with the state; or
3. The date on which the covered person becomes covered under any other plan providing similar benefits.

For the purposes of this section, "continuous total disability" and "totally disabled" shall mean:

1. For the covered employee, the inability to perform any work or occupation for which the covered person is reasonably qualified or trained; or
2. For any other covered person, the inability to engage in most normal activities of a person of like age and sex in good health.

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.

EXTENSION OF MATERNITY BENEFITS

For pregnancy, maternity benefits shall continue until the date of delivery provided the pregnancy began prior to the termination of this Health Plan. This extension shall not be based on total disability.

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 Department of Financial Services 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 18 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

The Health Plan has established and will maintain a process for hearing and resolving grievances raised by a covered person. Covered persons are required to first bring grievances to the attention of the Health Plan's member services department. Details regarding the grievance resolution process are included in the Member Handbook provided by the Health Plan.

There are two types of grievance procedures: informal and formal.

INFORMAL GRIEVANCE PROCEDURE

The Health Plan shall assist covered persons to resolve individual inquiries and problems without the initiation of a formal grievance. Any covered person who has an inquiry or complaint regarding a matter arising under this Health Plan should contact the Health Plan's customer service department for verbal resolution when possible.

FORMAL GRIEVANCE PROCEDURE

In the event the covered person's problem has not been settled at the informal level and the covered person is still dissatisfied, he or she shall be advised to file a formal written grievance. Grievance procedure requirements shall be available from the Health Plan. Additional information may be obtained by calling the Florida Health Maintenance Organization Hotline (1-800-226-1062) or the Department of Financial Services Consumer Hotline (1-800-342-2762).

The Health Plan shall acknowledge the complaint and shall investigate the grievance and notify the covered person of a final decision in writing after receipt of the grievance. In the case of a medical or quality of care grievance, the investigation shall include a review by a physician or physicians, including a physician other than the primary care physician.

Should a meeting with the covered person become necessary, the meeting shall be held at the Health Plan's administrative office within the covered person's service area or at a location within the service area convenient to the covered person.

If the covered person is not satisfied with the Health Plan's determination, he or she may appeal to the Health Plan's grievance committee by submitting a written request for review to the Health Plan. The grievance committee shall acknowledge receipt of the grievance, review the initial determination and any additional evidence submitted by the covered person and render a decision within a reasonable length of time not to exceed 60 days after receipt of a request for review unless the covered person and the Health Plan mutually agree to extend the time frame. Their findings and recommendations shall be final.

If a covered person is dissatisfied with the decision of the grievance committee, he or she may appeal to the Commissioner of the Florida Department of Financial Services or the Subscriber Assistance Panel in the Agency For Health Care Administration.

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. 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 the primary care physician, and what to do if emergency care is needed.

THE ROLE OF THE PRIMARY CARE PHYSICIAN

The first and most important decision each covered person must make when joining a health maintenance organization is the selection of a primary care physician. This decision is important since it is through this physician that all other health services, particularly those of specialists, are obtained. The covered person is free to choose any primary care physician listed in the Health Plan's list of primary care physicians whose practice is open to additional Health Plan covered persons, however the covered person should verify the physician's status through the Health Plan's member services staff of the Internet. This choice should be made when the covered person enrolls. If the covered person fails to choose a primary care physician when enrolling, the Health Plan shall assign one to the covered person and notify the covered person of that assignment. The selection or assignment of a primary care physician varies for health maintenance organizations.

Some important guidelines apply to the covered person's primary care physician relationship:

1. The primary care physician shall maintain a physician-patient relationship with the covered person, and shall be responsible for providing, authorizing and coordinating all medical services for the covered person.
2. The covered person must look to the primary care physician to direct his or her care, and should accept procedures and treatment recommended by the primary care physician.
3. Except in emergency situations or as otherwise directed by the Health Plan, all services shall be received from the covered person's primary care physician, from participating providers on referral from the primary care physician, 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 or that has not been referred by a primary care physician, services shall not be reimbursed by the Health Plan.

4. The Health Plan wants the covered person and the primary care physician to have a good relationship. Instances may occur where the primary care physician or the covered person, for good cause, finds it impossible to establish an appropriate and viable physician-patient relationship. In such a circumstance, the primary care physician or the covered person may request another primary care physician.
5. If for any reason the primary care physician or other contracting health care provider fails to or is unable to provide the covered person with services they have agreed to provide, the Health Plan agrees to provide, arrange or pay for services equivalent to those described in the covered services section up to the date for which payment has been made by the covered person.
6. If the covered person's primary care physician 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.

SPECIALTY CARE

The primary care physician may refer the covered person to participating specialists or facilities when medically necessary. The referral shall identify a course of treatment or specify the number of visits authorized for the diagnosis or treatment of the covered person's condition. Covered persons shall have direct access to gynecologists, dermatologists, chiropractors, podiatrists and other practitioners as specified by law.

When additional services or visits are suggested by the specialist, covered persons should first consult with their primary care physician, or Health Plan.

If a specialist beyond those participating with the Health Plan is required, the primary care physician shall authorize such treatment only if authorized by the Health Plan. As the procedures for specialty care vary for health maintenance organizations, the covered person is responsible for following the procedures established by the Health Plan.

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 primary care physician or 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. Each case outside the service area will be reviewed individually to determine whether the medical condition constituted a medical emergency.

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 primary care physician or 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 section describes the benefits that shall be covered under this Health Plan. It is important that this whole section be reviewed to be sure both covered benefit details and the limitations and exclusions are understood. Also, important information is contained in the schedule of member copayments.

Expenses for the services and supplies listed below shall be considered covered services under this Health Plan if the service is:

1. Required for a condition;
2. Rendered while coverage under this Health Plan is in force;
3. Not specifically limited or excluded under this Health Plan; and
4. Received from or provided under the orders, direction or authorized approval of the covered person's primary care physician or Health Plan, except for emergency care services.

HOSPITAL SERVICES

Expenses for the services and supplies listed below shall be considered covered benefits when furnished to a covered person at a hospital on an inpatient or outpatient basis, if the service or supply is ordered or authorized by the covered person's primary care physician or Health Plan:

1. Room and board for semi-private accommodations, unless the Health Plan has determined that private accommodations are medically necessary;
2. Confinement in an intensive care unit, progressive care unit, cardiac care unit or a neonatal care unit;
3. Routine nursery care for a newborn child;
4. Covered drugs and medicines used by the patient while confined in the hospital;
5. Respiratory therapy (including oxygen);
6. Covered rehabilitative services;
7. Use of operating rooms, labor rooms, delivery rooms, and recovery rooms;
8. Use of emergency rooms;
9. Intravenous solutions (including glucose);

10. Dressings, including ordinary casts, splints and trusses;
11. Anesthetics, related supplies, and their administration;
12. Transfusion supplies, services, and equipment (including blood, blood plasma, and serum albumin, if not replaced);
13. Diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing (including electrocardiogram (EKG) and electroencephalogram (EEG));
14. X-ray (including therapy);
15. Diathermy;
16. Basal metabolism examinations;
17. Chemotherapy treatment for proven malignant disease;
18. Private duty nursing; and
19. Other covered medically necessary services and supplies.

AMBULATORY SURGICAL CENTER SERVICES AND OTHER LICENSED OUTPATIENT MEDICAL TREATMENT FACILITIES

Expenses for the services and supplies listed below shall be considered covered benefits when furnished to a covered person at a participating provider ambulatory surgical center, any other appropriately licensed outpatient medical treatment facility, or a health care provider's office, if authorized by the covered person's primary care physician or Health Plan:

1. Use of operating rooms and recovery rooms;
2. Respiratory therapy (including oxygen);
3. Covered drugs and medicines used by the patient at the outpatient facility;
4. Intravenous solutions (including glucose);
5. Dressings, including ordinary casts, splints, and trusses;
6. Anesthetics, related supplies, and their administration;
7. Transfusion supplies, services, and equipment (including blood, blood plasma, and serum albumin, if not replaced);
8. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (including electrocardiogram (EKG) and electroencephalogram (EEG));
9. Basal metabolism examinations;
10. X-ray (including therapy);

11. Diathermy and physical therapy;
12. Chemotherapy treatment for proven malignant disease;
13. Services provided by a birthing center licensed pursuant to section 383.30-383.335, Florida Statutes; and
14. Other covered medically necessary services and supplies.

MEDICAL SERVICES

Expenses for the medical services and supplies listed below shall be considered covered benefits if provided or authorized by the covered person's primary care physician or Health Plan:

Alcoholism and substance abuse treatment, including expenses for the services and supplies listed in this section shall be considered covered benefits if provided to the covered person by a participating provider:

1. Inpatient confinement in a hospital, specialty institution, or residential facility for the treatment of alcoholism or substance abuse, if authorized by the Health Plan. Treatment shall be rendered by licensed mental health providers if services are provided in a facility accredited by the Joint Commission on Accreditation of Hospitals or approved by the state. Coverage is limited up to 31 days per calendar year.
2. Outpatient treatment rendered by licensed mental health providers and medical doctors licensed under chapter 458, and doctors of osteopathy licensed under chapter 459, Florida Statutes, if services are provided in a program accredited by the Joint Commission on Accreditation of Hospitals or approved by the state. Coverage is limited to 26 visits per calendar year.

Allergy treatment, including allergy testing, desensitization therapy, and allergy immunotherapy, including hyposensitization serum when administered by a health care provider.

Ambulance services, when medically necessary to transport a covered person from:

1. A hospital which is unable to provide proper care to the nearest hospital that can provide proper care;
2. A hospital to a covered person's home or skilled nursing facility when medically necessary; or
3. The place a medical emergency occurs to the nearest hospital that can provide proper care.

Ambulance services by boat, airplane, or helicopter shall be provided when it is determined that:

1. The pick-up point is inaccessible by ground transportation;

2. Speed in excess of ground vehicle speed is critical; or
3. The travel distance involved in getting the covered person to the nearest hospital that can provide proper care is too far for medical safety.

Anesthesia services, when administered by a health care provider and medically necessary for a covered medical or surgical procedure.

Cancer diagnosis and treatment, on an inpatient or outpatient basis, including chemotherapy treatment, covered transplants, x-ray, cobalt, and other acceptable forms of radiation therapy, microscopic tests or any covered lab tests or analysis made for diagnosis or treatment.

Casts and splints, including bite and dental splints for the treatment of temporomandibular joint (TMJ) syndrome.

Child health supervision services, which include health care services and supplies furnished to a covered person who is a dependent child and which are physician delivered or physician supervised shall be covered. This includes but is not limited to:

1. A newborn's first examination in the hospital;
2. 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;
3. Oral and/or injectable immunizations;
4. Laboratory tests normally performed for a well child;
5. Evaluation and management counseling and/or risk factor reduction intervention for covered dependents without symptoms or established illnesses;
6. Hearing screenings; and
7. Vision screening.
8. Cleft lip and cleft palate treatment for children under the age of 18 pursuant to s. 627.64193, Florida Statutes.

These services shall conform with prevailing medical standards and shall not be less than 18 visits at approximately the following age intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, and 16 years.

Concurrent physician care, including surgical assistance provided by a physician, provided the additional physician actively participates in the covered person's treatment and: a) the condition involves more than one body system or is so severe or complex that one physician cannot provide the care unassisted; b) the physicians have different specialties or have the

same specialty with different sub-specialties; and c) the care is authorized by the covered person's primary care physician or Health Plan.

Consultations, provided the covered person's primary care physician requests the consultation and the consulting physician prepares a written report.

Contraceptive supplies, including an IUD or diaphragm, their insertion and removal, contraceptive implants, their insertion and removal, and contraceptive injections.

Cosmetic surgery (plastic and reconstructive surgery) shall be a covered benefit if it is:

1. Necessary for the repair or alleviation of damage to a covered person if such treatment or surgery is the result of an accident sustained while the person is covered under the Health Plan and actually performed while the Health Plan is in force;
2. In connection with the correction of a congenital anomaly for an eligible dependent born while the Health Plan is in force;
3. A medically necessary procedure in the correction of an abnormal bodily function;
4. For reconstruction to an area of the body which has been altered by the treatment of a disease, provided such alteration occurred while a covered person under this Health Plan;
5. For reconstruction (including the initial prosthetic device) incident to a mastectomy when the mastectomy is performed on or after October 1, 1987, and there is evidence of malignancy; 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 if the mastectomy occurred while a covered person under this Health Plan; and
6. For a reduction mammoplasty, to reduce the size of the breast and the skin envelope if medically necessary.

Diagnostic procedures, lab tests or x-ray exams, including their interpretation, for the treatment of a covered condition.

Durable medical equipment and other medical supplies, when determined by the covered person's treating physician to be medically necessary for the care and treatment of a condition covered under this Health Plan. The durable medical equipment shall not, in whole or in part, serve as a comfort, hygiene, or convenience item for the covered person, shall not be used by any other party, shall not be used solely for the purpose of exercise, and shall have been manufactured specifically for medical use. At the Health Plan's option, the cost of either renting or purchasing shall be covered.

Durable medical equipment and other medical supplies are limited to:

1. Trusses, braces, walkers, canes, and crutches; however, no shoe build-up, shoe orthotic, shoe brace or shoe support shall be covered unless the shoe is attached to a brace;

2. Occlusal guards, bite or dental splints, repositioning devices, and TMJ study models for the treatment of temporomandibular joint (TMJ) syndrome;
3. Commode chairs, bedpans/urinals, decubitus care equipment, and ostomy and urinary products;
4. Oxygen and rental of equipment for the administration of oxygen, iron lung or other mechanical equipment for the treatment of respiratory paralysis;
5. Ambulatory home uterine activity monitoring devices (AHUM);
6. Wheelchairs, hospital beds, lumbar-sacral-orthosis (LSO) and thoracic-lumbar-sacral-orthosis (TLSO) braces, and traction equipment; and
7. Other medical equipment and supplies as determined to be medically necessary.

Eye care, limited to the following:

1. Routine or refractive eye examinations as part of the preventive medical care benefit or child health supervision services benefit;
2. The first pair of eyeglasses or contact lenses, including the examination for the prescribing or fitting thereof, only if due to an accident or cataract surgery;
3. Aphakic patients and soft lenses or sclera shells intended for use in the treatment of a covered condition; and
4. Following an injury, disease or accident to a covered person's eyes, while covered under this Health Plan.

Family planning services, including counseling and information on birth control, sex education and the prevention of sexually transmitted diseases (STD).

Hemodialysis for renal disease, including the equipment, training and medical supplies required for effective home dialysis and dialysis centers.

Home health care services provided by a home health agency for the appropriate treatment, therapy (including infusion therapy), equipment, medication, and supplies for a covered person as a result of a covered condition shall be covered by the Health Plan, subject to the following:

1. The covered person requires home health care visits;
2. The treating physician sends the covered person's primary care physician a home health care plan of treatment;
3. The covered person's primary care physician or Health Plan approves the plan of treatment in writing as being medically necessary and that the services are being provided in lieu of hospitalization or continued hospitalization; and

4. Home health care benefits would be less costly than confinement to a hospital or skilled nursing facility.

The covered person's primary care physician or Health Plan shall review the covered person's condition to determine the medical necessity for home health care services. If the covered person's condition does not warrant the services provided by a home health agency, nurse registry or independent nurse, benefits shall be denied. At such time as documentation is provided for and benefits are found to be medically necessary and in lieu of hospitalization or continued hospitalization, benefits shall be reinstated.

Home health care services include:

1. Part-time, intermittent or continuous nursing care by registered nurses, or licensed practical nurses, nurse registries or home health agencies;
2. Physical therapy, speech therapy, occupational therapy and respiratory therapy; and
3. Medical appliances, equipment, laboratory services, supplies, drugs, and medicines prescribed by a covered person's 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.

The covered home health care services under this benefit shall not include any service that would not have been covered had the covered person been confined in a hospital, or are solely for the convenience of the covered person. Physical therapy is subject to the limitations described under rehabilitative services.

Hospice services, in accordance with section 400.609, Florida Statutes, when hospice services are the most appropriate and cost effective treatment, as determined by the covered person's primary care physician or Health Plan. Covered persons who are diagnosed as having a terminal illness with a life expectancy up to one year may elect hospice care for such illness instead of the traditional services covered under this Health Plan.

To qualify for coverage, the covered person's primary care physician shall: (1) certify that the patient is not expected to live more than one year; (2) submit a written hospice care plan or program; and (3) submit a life expectancy certification. All hospice care expenses shall be approved in writing by the Health Plan. Covered persons who elect hospice care under this provision shall not be entitled to any other benefits under this Health Plan for the terminal illness while the hospice election is in effect. However, covered services rendered outside the hospice program for illnesses or accidents not related to the terminal illness shall be eligible for coverage subject to the Health Plan's benefits, limitations and exclusions. Under these circumstances, the following services shall be covered:

1. Hospice home care, comprised of:
 - a. Physician services, part-time or intermittent nursing care by a registered nurse or licensed practical nurse, or private duty nursing service;
 - b. Home health aides;

- c. Inhalation (respiratory) therapy;
 - d. Oxygen;
 - e. Medical supplies, drugs and appliances;
 - f. Physical, massage, speech, and occupational therapy to maintain the quality of life, if approved by the Health Plan as appropriate for special circumstances; and
 - g. Infusion therapy.
2. Hospice inpatient care in a hospice facility, hospital, or skilled nursing facility, if approved in writing by the Health Plan, including care for pain control or acute chronic symptom management. Inpatient services shall include:
 - a. Room and board and general nursing;
 - b. Other covered hospital inpatient services previously listed; and
 - c. All other services covered under home and outpatient hospice care.
 3. Hospice outpatient care provided by the hospice at an approved location shall include:
 - a. Physician services;
 - b. Laboratory, x-ray, and diagnostic testing;
 - c. Ambulance service; and
 - d. All other services covered under home hospice care services.

Social work services, bereavement, pastoral, financial, legal and dietary counseling, day care, homemaker, chore and funeral services are required to be provided by the hospice provider pursuant to section 400.609, Florida Statutes. However, these services are not covered services under this Health Plan.

The hospice treatment program shall:

1. Meet the standards outlined by the National Hospice Association;
2. Be recognized as an approved hospice program by the Health Plan;
3. Be licensed, certified, and registered as required by Florida law; and
4. Be directed by the covered person's primary care physician 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.

Immunizations, when medically necessary.

Insulin, including the needles and syringes needed for insulin administration when dispensed by a participating pharmacy or provider. However, the covered person shall have a physician's authorization for such supplies on record with the pharmacy where the supplies are purchased.

Mammograms performed for breast cancer screening, but limited to the following:

1. A baseline mammogram for women age 35 through 39;
2. A mammogram for women age 40 through 49, every two years or more frequently based upon the covered person's primary care physician recommendation;
3. A mammogram every year for women age 50 and over; and
4. A mammogram for covered persons of any age if deemed medically necessary by the covered person's primary care physician.

Mental and nervous disorders treatment, including expenses for the services and supplies listed in this section shall be considered covered benefits if provided to the covered person by a licensed mental health provider:

1. Inpatient confinement in a hospital, specialty institution, or residential facility, for the treatment of a mental and nervous disorder, if authorized by the Health Plan. Coverage includes visits from licensed mental health providers during confinement. Coverage is limited up to 31 days per calendar year.
2. Outpatient treatment rendered by a licensed mental health provider and medical doctors licensed under chapter 458, and doctors of osteopathy licensed under chapter 459, Florida Statutes, for a mental and nervous disorder, including diagnostic evaluation and psychiatric treatment, individual therapy, and group therapy. Coverage is limited to 26 visits per calendar year.

Mental and nervous disorders treatment shall not be a covered benefit if: (a) rendered in connection with a condition not classified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, (b) extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation, (c) for marriage counseling, (d) court ordered care or testing or required as a condition of parole or probation, (e) testing for aptitude, ability, intelligence or interest.

Newborn well-baby nursery services, while the newborn is hospital confined immediately following birth. These services also include the services provided by certified nurse midwives and midwives licensed pursuant to chapter 467, Florida Statutes, and birthing centers licensed pursuant to chapter 383, Florida Statutes.

Nutrition Counseling, when medically necessary.

Obstetrical services, for the covered employee or covered spouse, received on an inpatient or outpatient basis, including medically necessary prenatal and postnatal care of the mother. These services also include the services provided by certified nurse midwives licensed pursuant to chapter 464, Florida Statutes, and midwives licensed pursuant to chapter 467, Florida Statutes. However, medically necessary services in connection with the pregnancy of

eligible children due to the following complications of pregnancy shall be 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.

Oral surgery, for the surgical treatment of a 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 when medically necessary. This benefit includes, but is not limited to coverage for services related to an accident or injury occurring while, and as a result of, biting or chewing.

Outpatient Surgery, is defined as all surgical and invasive diagnostic procedures.

Oxygen, including the use of equipment for its administration.

Pap smears.

Pathologist services, on an inpatient or outpatient basis related to covered services.

Pre-admission tests, if medically necessary and when ordered or authorized by the covered person's primary care physician or Health Plan. However, the following conditions shall be met:

1. The tests shall be ordered or authorized by the covered person's primary care physician; and
2. The tests shall be performed in a facility accepted by the hospital and the Health Plan in place of the same tests which would normally be done while hospital confined.

Prescription drugs (dispensed by a pharmacy), which are prescribed by the covered person's primary care physician or other participating provider authorized to prescribe drugs within the scope of his or her license, and are received by the covered person, if those prescription drugs are purchased from a participating pharmacy, shall be subject to the following provisions:

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. Digoxin
2. Digitoxin
3. Warfarin
4. Conjugated estrogen
5. Quinidine gluconate
6. Dicumarol
7. Phenytoin
8. Chlorpromazine (solid oral dosage forms)
9. Theophylline (controlled release)
10. Levothyroxine sodium
11. Pancrelipase (oral dosage forms)

Covered prescription drugs:

1. Include any drug, medicine or medication that, under federal or state law, shall be dispensed only by prescription from a physician or other participating provider authorized to prescribe drugs within the scope of his or her license, or any compounded prescription containing such drug, medicine, or medication;
2. Include insulin, hypodermic needles and syringes with insulin on prescription, and FDA approved glucose strips and tablets, and chemstrip test tapes;
3. Shall be dispensed by a participating pharmacy;
4. Shall be a generic medication when both a generic and a more expensive brand name drug are available;
5. Shall be limited to a 30 day supply per prescription;
6. Shall include prepackaged items such as insulin, syringes, needles, FDA approved glucose strips and tablets, and chemstrip test tapes dispensed for the number of days' usage prescribed, or package quantity, whichever is greater; and
7. Include prescription refills, but shall not be covered until at least 75 percent of the previous prescription has been used by the covered person based on the dosage schedule prescribed by the physician or other participating provider authorized to prescribe drugs within the scope of his or her license.

No coverage shall be provided for:

1. Any drug, medicine or medication that is consumed at the place where the prescription is given or that is dispensed by a physician or other participating provider authorized to prescribe drugs within the scope of his or her license;
2. Any portion of a prescription or refill that exceeds a 30 day supply;
3. 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;
4. The administration of covered medication;
5. 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;
6. Prescriptions that may be properly received without charge under local, state, or federal programs, including workers' compensation;
7. Prescriptions ordered or received in excess of any maximums covered under this benefit, and not covered under any other provision in this Health Plan;
8. 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;
9. Immunizing agents;
10. Any drug or medicine that is lawfully obtainable without a prescription, with the exception of insulin;
11. Therapeutic devices or appliances, including hypodermic needles/syringes (exception: those items associated with an insulin prescription), support garments, and other non-medical substances, regardless of intended use;
12. Retin-A for cosmetic purposes;
13. Anti-obesity drugs;
14. Nicorette and similar drugs to deter smoking;
15. Amphetamines and/or anorexiant for weight loss;
16. Hormone treatment in preparation for sexual reassignment;
17. Any costs related to the mailing, sending or delivery of prescription drugs; and
18. Prescriptions filled at a non-participating pharmacy, except for prescriptions required during emergency care.

Preventive medical services, shall include but are not limited to:

A periodic health assessment examination performed or authorized by the covered person's primary care physician, which may include:

1. A health history;
2. A physical examination;
3. Laboratory tests which include urinalysis for blood, sugar, and acetone, and hemoglobin and hematocrit tests;
4. A stool for occult blood;
5. A tuberculin skin test;
6. Tests for sexually transmitted diseases;
7. Vision screening; and
8. Hearing screening.

For women, this examination may include a mammogram or a gynecological exam that also includes a manual breast exam, a pelvic exam, and a pap smear. For men, this examination may include a prostate gland screening.

This shall not include exams required for travel, or those needed for school, employment, insurance, or governmental licensing, unless the service is within the scope of, and coinciding with, the periodic health assessment exam. Only one exam per calendar year is allowed.

Prosthetic or orthotic devices, if medically necessary, including the initial placement of the most cost effective prosthetic or orthotic device, fitting, adjustments, and repair. Only when attached to a brace shall shoe orthotics be covered. The Health Plan shall also cover the replacement of such prosthetic or orthotic devices if it is determined by the covered person's primary care physician or the Health Plan to be necessary because of growth or change.

Radiologist services, on an inpatient or outpatient basis for covered services.

Rehabilitative services, including spine and back disorder treatment, manipulative services, physical, and speech therapy. The covered person's primary care physician or Health Plan shall specifically approve a written plan of treatment and agree that the covered person's condition should improve significantly within 60 days of the date therapy begins.

Coverage includes the services of licensed physical therapists, respiratory or inhalation therapists, chiropractors and physicians, and speech therapists, for the purpose of aiding in the restoration of normal physical function.

Rehabilitative services provided while the covered person is hospital confined shall be covered for the duration of the hospital confinement. Outpatient rehabilitative services are limited to 60 visits per injury.

Rehabilitative services do not include:

1. Services or supplies provided to a covered person as an inpatient in a hospital or other facility, where the admission is primarily to provide rehabilitative services;
2. Services or supplies that maintain rather than improves 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; or
3. Other therapy types including recreational, educational, marital or sleep therapy.

Respiratory therapy, including the services of respiratory or inhalation therapists and oxygen.

Second medical opinions, may be obtained if the Health Plan or covered person requests it for an elective surgery, or when a covered person questions the appropriateness or necessity of a covered surgical procedure, or is subject to a serious injury or illness.

With prior notice to the Health Plan, the covered person may obtain the second medical opinion from any licensed physician within the Health Plan's service area. All medically necessary tests relating to the second medical opinion may, however, be conducted by participating providers of the Health Plan.

If a participating physician is selected by the covered person, there shall be no cost to the covered person other than any applicable copayment. If a non-participating physician is selected by the covered person, 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.

The Health plan may restrict the use of second medical opinions in connection with a particular diagnosis or treatment to a maximum of three per calendar year.

Once a second medical opinion has been rendered, the Health Plan shall review and determine the treatment obligations of the Health Plan and that judgment shall be controlling. Any treatment obtained by the covered person that is not authorized by the Health Plan shall be at the covered person's expense.

Skilled nursing facility services shall be covered only if the covered person's primary care physician or Health Plan approves a written plan of treatment submitted by a physician and only if the covered person's primary care physician or Health Plan agrees that such skilled level services shall be provided in lieu of hospitalization or continued hospitalization and shall be subject to the following:

1. The covered person's primary care physician certifies the need for the skilled nursing facility and the covered person receives skilled nursing care or services on a daily basis;
2. The transfer to the skilled nursing facility shall be because the covered person requires skilled care for a condition (or related condition) which was treated in the hospital;

3. The covered person shall be admitted to the skilled nursing facility immediately following discharge from the hospital;
4. Services and supplies are limited to 60 days of confinement per calendar year and may include: room and board; respiratory therapy (e.g., oxygen); drugs and medicines administered while an inpatient; intravenous solutions; dressings, including ordinary casts; anesthetics and their administration; transfusion supplies and equipment; diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., electrocardiogram (EKG)); chemotherapy treatment for proven malignant disease; and other medically necessary services and supplies; and
5. Services shall be skilled level services, and shall be ordered by and provided under the direction of a physician.

Sterilization, limited to tubal ligations and vasectomies

Surgical procedures, performed on an inpatient or outpatient basis.

Transplantation of a covered tissue and organ transplant, as defined in this section, if approved by the Health Plan, and if performed at a facility approved by the Health Plan subject to the conditions and limitations described in this section and if in accordance with generally accepted professional medical standards and not experimental or investigational.

Transplantation includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. The Health Plan shall pay benefits only for services, care and treatment received for or in connection with the approved transplantation of the following human tissue or organs:

1. Cornea;
2. Heart;
3. Heart/lung
4. Whole single lung or whole bilateral lung;
5. Liver;
6. Kidney;
7. Kidney/pancreas; and
8. Bone marrow.

Coverage for bone marrow transplant procedures shall be updated as rules are recommended by the Bone Marrow Transplant Advisory Panel and adopted by the Director of the Agency for Health Care Administration pursuant to section 627.4236, Florida Statutes.

As used in this Health Plan, the term "bone marrow transplant" means human blood precursor cells which are administered to a patient following ablative or myelosuppressive therapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone

marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the harvesting, the transplantation and the chemotherapy components.

For a transplant procedure to be considered approved for this transplant benefit, prior approval from the Health Plan shall be required in advance of the procedure. The covered person's primary care physician shall notify the Health Plan in advance of the covered person's initial evaluation for the procedure in order for the Health Plan to determine if the transplant services shall be covered. For approval of the transplant itself, 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 transplant procedure shall be performed in a facility that has been authorized by the Health Plan. If approval is not given, benefits shall not be provided for the transplant procedure.

No benefit shall be payable for or in connection with a transplant if:

1. The organ involved is not listed in this section;
2. The Health Plan is not contacted for authorization prior to referral for transplant evaluation of the procedure;
3. The Health Plan does not approve coverage for the procedure;
4. Expenses are eligible to be paid under any private or public research fund, government program, or other funding program, whether or not such funding was applied for or received;
5. The expense relates to the transplantation of any non-human organ or tissue;
6. The service or supply is in connection with the implant of an artificial organ, including the implant of the artificial organ;
7. The organ is sold rather than donated to the covered person;
8. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by the Health Plan; or
9. A denied transplant is performed; this includes follow-up care, immunosuppressive drugs, and complications of such transplant.

The following services and supplies shall not be covered:

1. Artificial heart devices used as a bridge to transplant;
2. Drugs used in connection with diagnosis or treatment leading to a transplant when such drugs have not received FDA approval for such use; and
3. Any service or supply in connection with identification of a donor from a local, state, or national listing.

Once the transplant procedure is approved, the Health Plan shall advise the covered person's primary care physician of those facilities that have been authorized for the type of transplant procedure involved. Benefits shall be payable only if the pre-transplant services, the transplant procedure and post-discharge services are performed in a facility that has been licensed as a transplant facility.

For approved transplant procedures, and all related complications, the Health Plan shall cover only the following services:

1. Hospital expenses and medical expenses shall be paid under the hospital services benefit and medical services benefit in this Health Plan, 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
2. 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 than the donor's family or estate.

EXCLUSIONS AND LIMITATIONS

FOLLOWING COVERAGE ACCESS RULES

If covered persons do not follow the coverage access rules described in this section, the covered person risks having services and supplies received not covered by this Health Plan. In such a circumstance, the covered person would be responsible for reimbursing the Health Plan for the reasonable cost of the services rendered.

Covered persons shall remember that services that are provided or received without having been prescribed, directed or authorized in advance by the covered person's primary care physician or Health Plan, or if the service is beyond the scope of practice authorized for that health care provider under state law, except in cases of emergency care as described in this plan, are not covered unless such services otherwise have been expressly authorized under the terms of this Health Plan. Except for emergency care services, all services shall be received from participating providers on referral from the covered person's primary care physician or Health Plan.

Also, covered persons shall understand that services that, in the Health Plan's opinion, are not medically necessary shall not be covered. The ordering of a service by a physician, whether participating or non-participating, other than the covered person's primary care physician, or when expressly authorized by the primary care physician, does not in itself make such service medically necessary or a covered service.

EXCLUSIONS AND LIMITATIONS

The following services and supplies may be limited or excluded from coverage under this Health Plan:

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.

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.

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.

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.

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.

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.

SCHEDULE OF MEMBER COPAYMENTS

Covered Service	Unit	Copayment
<u>Copayment Maximums</u>		
Individual		\$1,500
Family		\$3,000
Lifetime Maximum Benefit		Unlimited
<u>Hospital Services</u>		
Inpatient hospital charge	Per admission	\$250
Outpatient facility charge	Per surgical procedure	\$0
Surgeon's charge	Per surgical procedure	\$0
<u>Emergency Services</u>		
At hospital in service area (copayment waived if admitted)	Per occurrence	\$50
At hospital outside service area (copayment waived if admitted)	Per occurrence	\$50
At Urgent Care Facility		\$25
<u>Ambulatory Surgical Center Services and Other Licensed Outpatient Medical Treatment Facilities</u>		
Facility charge	Per admission	\$0
Surgeon's charge	Per surgical procedure	\$0
<u>Medical Services</u>		
Ambulance services	Per trip	\$0
Diagnostic procedures, lab tests, X-ray exams or mammograms	Per occurrence	\$0
Durable medical equipment	Per device	\$0
Hemodialysis	Per treatment	\$0
Home health care	Per occurrence	\$0
Hospice services	Per occurrence	\$0
Limitation: 210 days maximum lifetime		
Maternity care	Initial visit only	\$25
surgeon's charge	Per surgical procedure	\$0
Primary Care office visit	Per visit	\$15
Specialist care office visit	Per visit	\$25
Well child care including immunizations	Per visit	\$0
Limitation: to age 16		

Preventive care (Including physical exams, eye exams, health education and counseling and immunizations)	Per visit	See OV copay
Hearing exam through age 17	Per visit	\$15
Annual well-woman care (Including pap smears)	Per visit	See OV copay
Routine mammography (based on established guidelines)	Per visit	\$0
Prosthetics	Per device	\$0
Radiation and chemotherapy therapy	Per treatment	\$0
Second medical and surgical opinion		
Participating Provider	Per visit	\$25
Non-Participating Provider	Per visit	40% of U&C
Non-Surgical Spine and Back services Limitation: 60 visits per injury	Per visit	\$25
Rehabilitative services Limitation: 60 visits per injury	Per visit	\$25
Skilled nursing facility services Limitation: 60 days per calendar year	Per confinement	\$0
Oral surgery Limited to accidents, injury or tempormandibular joint dysfunctions	Per visit	\$0
Insulin	Same as RX Brand copays per script	
Diabetic supplies		\$0
Hearing Aids		Not Covered
Family Planning		
Voluntary counseling	Per visit	\$25
Infertility diagnosis	Per visit	\$25
Infertility treatment	Per visit	Not Covered
Elective abortion	Per visit	Not Covered
Elective sterilization	Per visit	Copay depending on place of service
Vision care – at a participating Optometrist		
Refractive eye exams	Per visit	\$15
Contact Lenses	Per visit	\$69
Eyeglasses	Discounts available at participating provider	

Alcoholism and Substance Abuse Treatment

Inpatient detoxification/rehabilitation care Limitation: 31 days combined per calendar year	Per admission	\$250
Outpatient rehabilitation services Limitation: 26 visits per calendar year	Per visit	\$25

Mental and Nervous Disorders Treatment

Inpatient services in a hospital or psychiatric treatment facility Per admission \$250
Limitation: 31 days per calendar year

Outpatient services Per visit \$25
Limitation: 26 visits per calendar year

Prescription Drug Benefit

Formulary Copayment for prescription drugs filled or refilled at a participating pharmacy 30 day supply Generic
\$10
Brand
\$25

Formulary Oral contraceptives and supplies, 30-day supply . Including the insertion and removal of an IUD or Diaphragm, contraceptive implants, and Contraceptive injections. Generic
\$10
Brand
\$25

Non-Formulary Copayment for prescription drugs filled or refilled at a participating pharmacy 30 day supply Generic
\$10
Brand
\$40

Non-Formulary Oral contraceptives and supplies, 30-day supply . Including the insertion and removal of an IUD or Diaphragm, contraceptive implants, and Contraceptive injections Generic
\$10
Brand
\$40

Mail Order (Formulary) 90 day supply Generic
\$20
Brand
\$50

Mail Order (Non-Formulary) 90 day supply Generic
\$20
Brand
\$80

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.

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.

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 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),

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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.

OUTPATIENT SURGERY, is defined as all surgical and invasive diagnostic procedures.

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.

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.

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.

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 Department of Financial Services 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.

WELL-BABY HOSPITAL NURSERY SERVICES shall include those covered services and supplies associated with the care of a healthy newborn child.

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