IX. LIMITATIONS OF BASIC BENEFITS

9.01 Short-term Rehabilitative Therapy and Spinal Manipulation Services

All therapy services must be restorative in nature in order to be covered. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of injury or sickness. Restorative therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the injury or sickness.

Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an injury or sickness.

9.02 Breast Reconstruction and Breast Prostheses

Covered benefits for reconstructive surgery following a mastectomy include: occupational surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; post-operative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

9.03 Treatment or control of clinically severe (morbid) obesity:

Benefits for medical and surgical services for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer reviewed, evidence based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities. The following items are specifically excluded:

- Medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity; and
- Weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

9.04 Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided that:

- the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
- the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease or;
- the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.
The following is an excerpt from the Summary Plan Description for the Miami-Dade County POS Health Plan

9.05 Genetic Testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per contract year for both pre and post genetic testing.

9.06 Nutritional Evaluation made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

9.07 Durable Medical Equipment is limited to the lowest-cost alternative as determined by AvMed. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person’s misuse are the person’s responsibility.

9.08 External Prosthetic Appliances and Devices made or ordered by a Physician for the initial purchase and fitting of external prosthetic appliances and devices available only by prescription necessary for the alleviation or correction of injury, sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by AvMed.

9.09 Replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Coverage for replacement is limited as follows:

- No more than once every 24 months for persons 19 years of age and older and
- No more than once every 12 months for persons 18 years of age and under.
- Replacement due to a surgical alteration or revision of the site.

9.10 Custom foot orthoses are only covered as follows:

- for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
- when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
- when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
The following is an excerpt from the Summary Plan Description for the Miami-Dade County POS Health Plan

- for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

Coverage is limited to the first such item; replacement is covered only when Medically Necessary due to a change in bodily configuration. Replacement for damage due to abuse or misuse by the person will not be covered.

9.11 Wigs/cranial prostheses are limited to a lifetime maximum of $300 when related to restoration after cancer or brain tumor treatment.

9.12 Other Health Care Facility (ies). All routine services of Other Health Care Facilities (see Section 2.40), including Physician visits, physiotherapy, diagnostic imaging and laboratory work, are covered for a maximum of sixty (60) days per calendar year when a Member is admitted to such a facility, for a condition that cannot be adequately treated with Home Health Care Services, or on an ambulatory basis.

9.13 Abortion Services. Abortion services are covered when medically necessary.

9.14 Transplant Services. Transportation benefits for transplant services are administered through Optum Health, an AvMed third party partner. Benefits are limited to $200 per day up to $10,000 lifetime maximum for a companion to accompany the Member (or two companions when the patient is a minor) and the member has to travel greater than a 50 mile radius to receive the transplant. This is a benefit available only when the transplant is authorized at one of AvMed’s transplant contracted facilities nationwide.

9.15 Habilitative physical, occupational, & speech therapy services, when provided for the treatment of Autism Spectrum Disorder, are covered to a combined maximum of 100 visits per calendar year.
Medical Services and benefits for the following classifications and conditions are not covered and are excluded from this Benefit Plan:

10.01 Expenses for supplies, care, treatment, or surgery that are not Medically Necessary.

10.02 To the extent that you or any one of your covered Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.

10.03 To the extent that payment is unlawful where the person resides when the expenses are incurred.

10.04 Charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government:
   • unless there is a legal obligation to pay such charges whether or not there is insurance; or
   • if such charges are directly related to a military-service-connected Injury or Sickness.

10.05 Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.

10.06 Charges for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
   • not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
   • not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
   • the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section of this plan; or
   • the subject of an ongoing phase I, II or III clinical trial, except as provided in the “Clinical Trials” section of this plan.

10.07 Cosmetic surgery and therapies defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.

10.08 Regardless of clinical indication, charges for macromastia surgery; surgical treatment of abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

10.09 Charges for or in connection with treatment of the teeth or periodontium unless such expenses are incurred:
   • for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; or
   • made by a Hospital for Bed and Board or Necessary Services and Supplies; or
   • made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery; or
   • charges made by a Physician for any of the following Surgical Procedures: excision of epulis; excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who
extracted the tooth); intraoral drainage of acute alveolar abscess with cellulitis; alveolectomy; gingivectomy, for gingivitis or periodontitis.

10.10 Medical and surgical services, initial and repeat, intended for the treatment or control of obesity are not covered except for surgery for morbid obesity, as shown in Covered Expenses. Services not covered include medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

10.11 Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.

10.12 Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.

10.13 Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

10.14 Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation. Sexual dysfunction benefits are not available for drug therapies except certain drugs approved by the Plan and only to treat erectile dysfunction due to organic cause.

10.15 Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.

10.16 Non-medical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, or mental retardation.

10.17 Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.

10.18 Private Hospital rooms unless semi-private rooms are not available and/or private duty nursing except as provided under the Home Health Services provision.

10.19 Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

10.20 Orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs (except under section 9.11).

10.21 Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except for cochlear implants in deaf children. A hearing aid is any device that amplifies sound.

10.22 Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
10.23 Medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.

10.24 Charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.

10.25 Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

10.26 Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

10.27 Genetic screening or pre-implantations genetic screening. General population-based genetic screening performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

10.28 Dental implants for any condition.

10.29 Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

10.30 For or in connection with an Injury or Sickness which is due to war, declared or undeclared.

10.31 Any sickness or injury for or in connection with any injury or sickness arising out of, or in the course of, any employment for wage or profit; including any sickness or injury for which the covered person is covered (or required to be covered) by Workers' Compensation. In addition, if the covered person enters into a settlement giving up rights to recover past or future medical benefits under a Workers’ Compensation law, AvMed shall not cover past or future Medical Services that are the subject of or related to that settlement. Furthermore, if the covered person is covered by a Worker’s 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, AvMed shall not cover the balance of any costs remaining after the program has paid.

10.32 Telephone, e-mail, and Internet consultations and telemicine.

10.33 Massage therapy.

10.34 For charges which would not have been made if the person had no insurance.

10.35 To the extent that they are more than Maximum Reimbursable Charges.

10.36 Expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.

10.37 To the extent of the exclusions imposed by any certification requirement shown in this plan.

10.38 The following are specifically excluded from Mental Health and Substance Abuse Services:
   - Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
   - Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
The following is an excerpt from the Summary Plan Description for the Miami-Dade County
POS Health Plan

- Developmental disorders, including but not limited to, developmental reading disorders,
developmental arithmetic disorders, developmental language disorders or developmental
articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.

10.39 The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or
  who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the Plan; and
- for services or supplies that are primarily to aid you or your Dependent in daily living.

10.40 Durable Medical Equipment items that are not covered include but are not limited to those that
are listed below:

- Bed Related Items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom
  equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic
  mattresses.
- Bath Related Items: bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet
  seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- Chairs, Lifts and Standing Devices: computerized or gyroscopic mobility systems, roll about
  chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts
  (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person
  transfer), and auto tilt chairs.
- Fixtures to Real Property: ceiling lifts and wheelchair ramps.
- Car/Van Modifications.
- Air Quality Items: room humidifiers, vaporizers, air purifiers and electrostatic machines.
- Blood/Injection Related Items: blood pressure cuffs, centrifuges, nova pens and needle less
  injectors
- Other Equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-
  controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage
  board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair
  gliders, elevators, saunas, any exercise equipment and diathermy machines.

10.41 The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used
  postoperatively for synostotic plagiocephaly. When used for this indication, the cranial
  orthosis will be subject to the limitations and maximums of the External Prosthetic
  Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and
  transfers;
- orthoses primarily used for cosmetic rather than functional reasons;
- orthoses primarily for improved athletic performance or sports participation; and
• Copes scoliosis braces.

10.42 The following are specifically excluded external prosthetic appliances and devices:
• External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
• Myoelectric prostheses peripheral nerve stimulators.

10.43 The following are specifically excluded infertility services:
• Artificial insemination
• In vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;
• Reversal of male and female voluntary sterilization;
• Infertility services when the infertility is caused by or related to voluntary sterilization;
• Donor charges and services;
• Cryopreservation of donor sperm and eggs; and
• Any experimental, investigational or unproven infertility procedures or therapies.

10.44 Short-term Rehabilitative Therapy and Spinal Manipulation Services that are not covered include but are not limited to:
• sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
• treatment for functional articulation disorder such as correction of tongue thrust, lips, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury;
• services that are custodial, instructional, educational or developmental in nature;
• therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

10.45 The following are specifically excluded from Spinal Manipulation Services:
• services of a chiropractor which are not within his scope of practice, as defined by state law;
• charges for care not provided in an office setting; and
• vitamin therapy.

10.46 Speech therapy for delayed or abnormal speech pathology. In cases where a child is born deaf, the Plan would evaluate coverage for treatment options, including speech therapy and implants, based on the likelihood for successful outcome.

10.47 Clinical Trials: Routine patient services do not include, and reimbursement will not be provided for: Charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government.

In addition, the following criteria must be met:
• the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
• the trial investigates a treatment for terminal cancer and: (1) the person has failed standard therapies for the disease; (2) cannot tolerate standard therapies for the disease; or (3) no effective non-experimental treatment for the disease exists;
• the person meets all inclusion criteria for the clinical trial and is not treated “off-protocol”;

SF-MDC-POS-LE-15
SF-3447 (01/15)
The following is an excerpt from the Summary Plan Description for the Miami-Dade County POS Health Plan

- the trial is approved by the Institutional Review Board of the institution administering the treatment; and
- coverage will not be extended to clinical trials conducted at nonparticipating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.

Clinical Trials: Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed herein as Exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

10.48 Surgery for the augmentation of the size of the breasts except as required for the comprehensive treatment of breast cancer. Surgery for the reduction of the size of the breasts, except as required for the comprehensive treatment of breast cancer, is not covered unless deemed Medically Necessary by the Medical Director.

10.49 Nutritional supplies and formulae except for infant formula needed for the treatment of inborn errors of metabolism.

10.50 Complication of a non-covered service is not covered.