AvMed Elite Plan for Small Groups

Medical and Hospital Service Contract with Point of Service Rider

James M. Repp
President & COO

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AVMED CORPORATE OFFICE
3470 NW 82ND AVENUE
DORAL, FLORIDA 33122

AVMED MEMBER ENGAGEMENT CENTER - ALL AREAS
1-800-376-6651

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SERVICE AREA OFFICES

GAINESVILLE
4300 NW 89th Boulevard
Post Office Box 749
Gainesville, Florida 32627-0749
(352) 372-8400
(800) 346-0231

DORAL
3470 NW 82nd Avenue
Doral, Florida 33122
(305) 671-5437
(800) 432-6676

AVMED ELITE PLAN FOR SMALL GROUPS
MEDICAL AND HOSPITAL SERVICE CONTRACT
WITH POINT OF SERVICE RIDER

IN CONSIDERATION of the payment of pre-paid monthly Premiums as provided herein, AvMed, Inc., a private Florida not-for-profit corporation, state licensed as a health maintenance organization under Chapter 641, *Florida Statutes* (hereinafter, "AvMed"), and the Subscribing Group as named on the Group Master Application (hereinafter "Subscribing Group"), agree as follows:

I. INTRODUCTION

1.1 **Provision of Health Care Services and Benefits.** The Subscribing Group engages AvMed, on behalf of the group health plan described in this Contract, to arrange for the provision of Covered Services which are Medically Necessary for the diagnosis and treatment of Members of the Subscribing Group. AvMed arranges for the delivery of Covered Services in accordance with the covenants and conditions contained in this Contract and does not directly provide these Covered Services. AvMed will rely upon the statements of the Subscriber in their application in arranging for the provision of Covered Services under this Contract.

1.2 **Interpretation.** To provide the advantages of Hospital and medical facilities and of In-Network Providers, AvMed operates on a direct service rather than indemnity basis. The interpretation of this Contract will be guided by the direct service nature of AvMed's program, and the definitions and other provisions contained in this Contract.

1.3 **Important Considerations.** When reading your Contract, please remember:

a. You should read this Contract in its entirety to determine if a Health Care Service is covered.

b. Many of the provisions of this Contract are interrelated. Reading just one or two provisions may give you a misleading impression. The headings of Parts and Sections contained in this Contract are for reference purposes only and will not affect the meaning or interpretation of provisions.

c. Many words used in this Contract have special meanings. Words or phrases that start with a capital letter, are either the first word in a sentence, a proper name, a title, or a defined term. If a word or phrase has a defined meaning, it will either be in Part II. DEFINITIONS, or defined within the section where it is used.

1.4 **References in this Contract**

a. References to "you" or "your" refer to you as the Subscriber and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references which refer solely to you as the Subscriber or solely to your Covered Dependents will be noted as such.

b. References to "we," "us," and "our" refer to AvMed.

c. References to the "Plan" refer to this AvMed Elite Plan for Small Groups.

d. Whenever used, the singular will include the plural and the plural the singular.

1.5 **Shared Savings Incentive Program.** This Contract is eligible for the Shared Savings Incentive Program per Section 641.31076, F.S. This voluntary program allows Members to participate in the savings generated from Shoppable Health Care Services located at providers on AvMed's shared savings list.

a. AvMed's shared savings list is available at www.avmed.org/smartshopper. This list includes all available Shoppable Health Care Services and their Shared Savings Incentive amount. Be aware, this list may change. Please check frequently to ensure you have accurate information.

b. When you qualify for a reward, your Shared Saving Incentive will be sent to you by check approximately 30 days after we confirm that you received care at an incentive eligible location.

c. AvMed must notify you, and the Office of Insurance Regulation, at least 30 days before termination of this program.

1.6 **Contract Renewal.** This Contract is guaranteed renewable and will stay in effect while the Subscribing Group meets and continues to meet the eligibility guidelines set forth in the Group Master Application and Premiums are paid on time. The Subscribing Group and Members are subject to all terms, conditions, Limitations, and Exclusions in this Contract and to all the rules and regulations of the Plan. By paying Premiums or having Premiums paid on your behalf, you accept the provisions of this Contract.

1.7 **You must notify us immediately of any address change** (or email us if you have opted for electronic communications).

II. DEFINITIONS

As used in this Contract, each of the following terms has the meaning indicated. You may visit www.healthcare.gov/glossary to review the definitions included in the Uniform Glossary provided as a result of the Affordable Care Act.

2.1 **Accidental Dental Injury** means an injury to Sound Natural Teeth (not previously compromised by decay) caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to Sound Natural Teeth caused by biting or chewing, surgery or treatment for a disease or illness.

2.2 **Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in the Plan; and including:

a. a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any Utilization Management Program, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational, or not Medically Necessary; and

b. a cancellation or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required Premiums or contributions toward the cost of coverage.

2.3 **Allowed Amount** means the maximum amount established by AvMed upon which payment will be based for Covered Services rendered by In-Network Providers; and by Out-of-Network Providers when rendered in connection with an AvMed authorized visit in an in-network health care facility if the Member has not proactively elected to receive such services from an Out-of-Network Provider. The Allowed Amount may be changed at any time without notice to you or your consent.

2.4 **Ambulatory Surgery Center** means a facility licensed pursuant to Chapter 395, *Florida Statutes* (or if outside Florida, applicable state law), the primary purpose of which is to provide surgical care to a patient admitted to, and discharged from, such facility within 24 hours.

2.5 **Attending Physician** means the Physician primarily responsible for the care of a Member with respect to any Condition.

2.6 **AvMed Network Provider** or **AvMed Provider Network** means the Health Care Providers with whom AvMed has contracted or made arrangements to provide Covered Benefits and Covered Services to AvMed Elite Plan Members. AvMed Network Providers are also referred to as "In-Network Providers."

2.7 **Benefit Level** means:

a. For In-Network Providers the Copayment or Coinsurance percentage of the Allowed Amount for Covered Services, after any applicable Calendar Year Deductible is met. Benefits for Covered Services received from In-Network Providers are payable at the high Benefit Level.

b. For Out-of-Network Providers, the Copayment or Coinsurance percentage of the Maximum Allowable Payment for Covered Services, after the applicable Calendar Year Deductible is met. Benefits for Covered Services received from Out-of-Network Providers are payable at the low Benefit Level. However, if a Member receives authorized Health Care Services from an Out-of-Network Provider during a visit in an in-network health care facility, and the Member did not

proactively elect to receive such services from an Out-of-Network Provider, the services will be payable at the high Benefit Level.

2.8 **Birthing Center** means a facility licensed pursuant to Chapter 383, *Florida Statutes* (or if outside Florida, applicable state law), which is freestanding, and is not 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. Birthing Centers must provide facilities for obstetrical delivery and short-term recovery after delivery, care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse midwife and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post- delivery confinement.

2.9 **Breast Reconstructive Surgery** means surgery to reestablish symmetry between the two breasts following breast cancer treatment.

2.10 **Calendar Year Deductible** means the first payments up to a specified dollar amount that a Member must make in the applicable calendar year for Covered Benefits. It is the amount you owe for certain Covered Services before AvMed begins to pay and must be satisfied once each calendar year. The Calendar Year Deductible may not apply to all services. The Deductible applies to each Member, subject to any family Deductible listed on the Schedule of Benefits. For purposes of the Deductible, "family" means the Covered Employee and Covered Dependents. Third-party Copayment assistance by a drug manufacturer or any other entity toward your cost-sharing for Covered Services including Specialty Medications, does not apply toward satisfaction of the Deductible.

2.11 **Calendar Year Out-of-Pocket Maximum** means the maximum amount you will pay during a calendar year before AvMed begins to pay 100% of the Allowed Amount or Maximum Allowable Payment for Covered Services during the same calendar year. This limit never includes your Premiums, Prescription Drug Brand Additional Charges, third-party Copayment assistance by a drug manufacturer or any other entity toward your cost-sharing for Covered Services including Specialty Medications, charges in excess of the Maximum Allowable Payment for Covered Services rendered by Out-of-Network Providers, or charges for health care that AvMed does not cover.

2.12 **Claim** means a request for benefits under this Contract, made by or on behalf of a Member in accordance with AvMed's procedures for filing benefit Claims.

a. Pre-Service Claim means any Claim for benefits under this Contract for which, in whole or in part, a Claimant must obtain authorization from AvMed in advance of such services being provided to or received by the Member.

b. Urgent Care Claim means any Claim for medical care or treatment for a Condition that could seriously jeopardize the Member's life or health, or the Member's ability to regain maximum function or, in the opinion of a Physician with knowledge of the Member's Condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment requested.

c. Concurrent Care Claim means any request by a Claimant that relates to an Urgent Care Claim to extend a course of treatment beyond the initial period or number of treatments previously approved.

d. Post-Service Claim means any Claim for benefits under this Contract that is not a Pre-Service Claim.

2.13 **Claimant** means a Member or a Member's authorized representative acting on behalf of a Member. AvMed may establish procedures for determining whether an individual is authorized to act on behalf of a Member with respect to a Claim for benefits.

2.14 **Coinsurance** means the portion of the cost for a Covered Service that a Member must pay once any applicable Deductible has been met, and is expressed as a percentage, established solely by AvMed, of the Allowed Amount or Maximum Allowable Payment for the Covered Service, or the percentage of an amount based on the Maximum Medicare Allowable or Average Wholesale

Price for the Covered Service. Members are responsible for the payment of any applicable Coinsurance directly to a Health Care Provider at the time Covered Services are received.

2.15 **Condition** means a disease, illness, ailment, injury, or pregnancy.

2.16 **Contract** means this AvMed Elite Plan Medical and Hospital Service Contract with Point of Service Rider, which may at times be referred to as **"Group Contract"** or **"Subscribing Group Contract"** and all Applications, Rate Letters (as described in Part XVII. GENERAL PROVISIONS), schedules, amendments, and any other document approved by the Florida Office of Insurance Regulation for incorporation into this Contract.

2.17 **Copayment** means the fixed dollar amount, established solely by AvMed, that a Member must pay once any applicable Deductible has been met, for certain Covered Services rendered by a Health Care Provider at the time the Covered Services are received. The Copayment is a portion of the Allowed Amount or Maximum Allowable Payment for the Covered Service, or a portion of the Maximum Medicare Allowable or Average Wholesale Price, for the Covered Service.

2.18 **Coverage Criteria** are medical and pharmaceutical protocols used to determine payment of products and services and are based on independent clinical practice guidelines and standards of care established by government agencies and medical/pharmaceutical societies. AvMed reserves the right to make changes to Coverage Criteria for covered products and services.

2.19 **Covered Benefits** or **Covered Services** means those Health Care Services to which a Member is entitled under the terms of this Contract. Member's cost-sharing responsibilities for Covered Services, including any applicable Deductible, Copayments and Coinsurance amounts, are outlined in the Schedule of Benefits.

2.20 **Covered Dependent** means any dependent of a Subscriber's family, who meets and continues to meet all applicable eligibility requirements, and who is enrolled and covered under this Contract other than as a Subscriber.

2.21 **Custodial** or **Custodial Care** means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care essentially is personal care that does not require the continuing attention of trained medical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the frequency, intensity and level of care, medical supervision required and furnished, patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

2.22 **Dental Care** means:

a. dental x-rays, examinations and treatment of the teeth or any services, supplies or charges related to:
   i. the care, filling, removal, or replacement of teeth; or
   ii. the treatment of injuries to, or disease of, the teeth, gums or structures directly supporting or attached to the teeth, which are customarily provided by dentists (including orthodontics, reconstructive jaw surgery, casts, splints, and services for dental malocclusion).

b. Dental Care is covered only for children through the end of the month in which they turn 19, except as described in Part IX COVERED MEDICAL SERVICES. For more information about covered pediatric dental benefits please see Part XVIII. PEDIATRIC DENTAL BENEFITS.

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

2.24 **Domestic Partner** means an unmarried adult who:

a. cohabits with you in an emotionally committed and affectional relationship that is meant to be of lasting duration;
b. is not related by blood or marriage;
c. is at least 18 years of age;
d. is mentally competent to consent to a contract;
e. has filed a domestic partnership agreement or registration with the Subscribing Group, if available, in the state (and/or city) of residence;
f. has shared financial obligations including basic living expenses for the twelve-month period prior to enrollment in the Plan;
g. provides documentation satisfactory to AvMed as evidence of a Domestic Partner relationship; and
h. meets the dependent eligibility requirements of this Plan.

2.25 **Durable Medical Equipment (DME)** is any equipment that meets all the following requirements:

a. can withstand repeated use; and
b. is primarily and customarily used to serve medical purposes; and
c. generally, is not useful to a person in the absence of a Condition; and
d. is appropriate for use in the Member's home.

2.26 **Emergency Medical Condition** means:

a. A Condition, including a mental health Condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following:
    i. serious jeopardy to the health of a patient, including a pregnant woman or her unborn child;
    ii. serious impairment to bodily functions; or
    iii. serious dysfunction of any bodily organ or part; and
    iv. with respect to a pregnant woman:
        1) that there is inadequate time to effect safe transfer to another Hospital prior to delivery;
        2) that a transfer may pose a threat to the health and safety of the patient or unborn child; or
        3) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.
b. Examples of Emergency Medical Conditions include heart attack, stroke, massive internal or external bleeding, fractured limbs, or severe trauma.

2.27 **Emergency Medical Services and Care** means medical screening, examination, and evaluation by a Physician or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Physician, to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a Covered Service by a Physician necessary to relieve or eliminate the Emergency Medical Condition within the service capability of the Hospital or independent freestanding emergency department. The determination as to whether or not an illness or injury constitutes an Emergency Medical Condition will be made by AvMed and may be made retrospectively based upon all information known at the time the Member was present for treatment.

a. <u>In-area emergency</u> does not include elective or routine care, care of minor illnesses or care that can reasonably be sought and obtained from the Member's Physician, inside the Service Area.
b. <u>Out-of-area emergency</u> does not include care for Conditions for which a Member could reasonably have foreseen the need for such care before leaving the Service Area or care that could safely be delayed until prompt return to the Service Area.

2.28 **Essential Health Benefits** has the meaning set forth under the Affordable Care Act, Section 1302(b), and applicable regulations. The ten categories of Essential Health Benefits are:

a. ambulatory patient services;
b. emergency services;
c. hospitalization;
d. maternity and newborn care;
e. mental health and substance use disorder services (including behavioral health treatment);
f. prescription drugs;
g. rehabilitative and habilitative services and devices;
h. laboratory services;
i. preventive and wellness services and chronic disease management;
j. pediatric services (including oral and vision care).

2.29 **Exclusion** means any provision of this Contract whereby coverage for a specific hazard, service or Condition is entirely eliminated.

2.30 **Experimental or Investigational** means:

a. 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 AvMed:
    i. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to the Member;
    ii. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;
    iii. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;
    iv. credible scientific evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine maximum tolerated dosages, toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
    v. credible scientific evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine maximum tolerated dosages, toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
    vi. credible scientific evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for 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.
b. Credible scientific evidence is defined by AvMed as one of the following:
    i. records maintained by Physicians or Hospitals rendering care or treatment to the Member or other patients with the same or similar Condition;
    ii. reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;

iii. 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;

iv. the written protocol or protocols relied upon by the Attending Physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device;

v. the written informed consent used by the Attending Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or

vi. 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.

2.31 **Full-Time Student** or **Part-Time Student** means one who is attending a recognized and accredited college, university, vocational or secondary school and is carrying sufficient credits to qualify as a Full-Time or Part-Time Student in accordance with the requirements of the school.

2.32 **Habilitation Services** are services that help a person keep, learn, or improve skills and functioning for daily living. Such services may be provided for a person to attain and maintain a skill or function never learned or acquired due to a disabling Condition. They are services that are deemed necessary to meet the needs of individuals with developmental disabilities in programs designed to achieve objectives of improved health, welfare and the realization of individuals' maximum physical, social, psychological, and vocational potential for useful and productive activities.

2.33 **Health Care Providers** means Health Professionals and includes institutional providers, such as Hospitals, Medical Offices or Other Health Care Facilities that are engaged in the delivery of Health Care Services and are licensed and practice under an institutional license or other authority consistent with state law.

2.34 **Health Care Services** (except as limited or excluded by this Contract) means the services of Health Professionals, including medical, surgical, diagnostic, therapeutic and preventive services that are:

a. generally, and customarily provided in the Service Area;

b. performed, prescribed, or directed by Health Professionals acting within the scope of their licenses; and

c. Medically Necessary (except for preventive services as stated herein) for the diagnosis and treatment of Conditions.

2.35 **Health Professionals** means allopathic and osteopathic Physicians, podiatrists, chiropractors, physician assistants, nurses, licensed clinical social workers, pharmacists, optometrists, nutritionists, occupational therapists, physical therapists, certified nurse midwives and midwives, and other professionals engaged in the delivery of Health Care Services, who are appropriately licensed under applicable state law.

2.36 **Home Health Care Services (Skilled Home Health Care)** means Physician-directed professional, technical and related medical and personal care services provided on an intermittent or part-time basis directly by (or indirectly through) a home health agency in your home or residence. Such services include professional visiting nurses or other Health Professionals for services covered under this Contract. For purposes of this definition, a Hospital, Skilled Nursing Facility, nursing home or other facility will not be considered a home or residence.

2.37 **Hospice** means a public agency or private organization licensed pursuant to Chapter 400, *Florida Statutes* (or if outside Florida, applicable state law), to provide Hospice services. Such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill Members and their families.

2.38 **Hospital** means a facility licensed pursuant to Chapter 395, *Florida Statutes* (or if outside Florida, applicable state law), that offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services

and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

a. The term Hospital does not include an Ambulatory Surgery Center; Skilled Nursing Facility; stand-alone Birthing Center; convalescent, rest, or nursing home; or facility which primarily provides Custodial, educational, or rehabilitative therapies.

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

2.39 **Hospital-owned or affiliated** means under common ownership, licensure, or control of a Hospital. As may be noted in your Schedule of Benefits, the cost-sharing for some services can vary depending on whether they are obtained at a Hospital-owned or Hospital-affiliated facility. Also see **Independent Facility** below.

2.40 **Identification Card** means the cards AvMed issues to Members. The card is our property and is not transferable to another person. Possession of such card in no way verifies that an individual is eligible for, or covered under, this Contract.

2.41 **Independent Facility** means a facility not under common ownership, licensure, or control of a Hospital. The cost-sharing for certain services may vary depending on whether they are obtained at an Independent Facility.

2.42 **Injectable Medication** means a medication that is approved by the U.S. Food and Drug Administration (FDA) for administration by one or more of the following routes: intra-articular, intracavernous, intramuscular, intraocular, intrathecal, intravenous, or subcutaneous injection; or intravenous infusion. Medications intended to be injected or infused by a Health Professional are generally covered as a medical benefit. Prior Authorization may be required for Injectable Medications.

2.43 **In-Network Physician** or **In-Network Provider** means any Health Care Provider with whom AvMed has contracted or made arrangements to render the Covered Benefits and Covered Services described in this Contract to AvMed Elite Plan Members. For a listing of In-Network Providers, please refer to your AvMed Elite Plan Provider Directory or visit our online directory at www.avmed.org.

2.44 **Intensive Outpatient Treatment** means treatment in which an individual receives at least three clinical hours of institutional care per day (24-hour period) for at least three days a week and returns home or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital will not be considered a 'home' for purposes of this definition.

2.45 **Limitation** means any provision other than an Exclusion that restricts coverage under this Contract.

2.46 **Master Application** means the Subscribing Group application form entitled 'Group Master Application' which becomes a part of the Contract when the Group Master Application has been completed and executed by the Subscribing Group and AvMed.

2.47 **Material Misrepresentation** means the omission, concealment of facts or incorrect statements made on any application or enrollment forms by an applicant, Subscriber or Covered Dependent which, had they been known, would have affected our decision to issue this Contract, the issuance of different benefits, or the issuance of this Contract only at a higher rate.

2.48 **Maximum Allowable Payment** means the maximum amount, as established by AvMed, which AvMed will pay for any Covered Service rendered by an Out-of-Network Provider or supplier of services, medications, or supplies as defined in this Contract. The Maximum Allowable Payment may be changed at any time by AvMed without notice to you or your consent. You may obtain an estimate of the Maximum Allowable Payment for services from Out-of-Network Providers by contacting AvMed's Member Engagement Center at the telephone number on the cover of this

Contract, or on your AvMed Identification Card. The fact that we may provide you with such information does not mean, and will not be construed to mean, that the service is a Covered Benefit. All terms and conditions included in your Contract apply.

2.49 **Medical Office** means any outpatient facility or Physician's office within the Service Area utilized by a Health Professional.

2.50 **Medical Supplies – outpatient disposable.** Outpatient disposable Medical Supplies means disposable medical supplies that are prescribed by a Physician for outpatient use; are usable only by the Member for whom they are prescribed; have no further use when the medical need ends; and are not primarily for comfort or hygiene, environmental control, or exercise.

2.51 **Medically Necessary** or **Medical Necessity** means the use of any appropriate medical treatment, service, equipment and/or supply as provided by a Health Care Provider which is necessary, as determined by AvMed, for the diagnosis, care, or treatment of a Member's Condition, and which is:

a. consistent with the symptoms, diagnosis, and treatment of the Member's Condition;
b. the most appropriate level of supply and/or service for the diagnosis and treatment of the Member's Condition;
c. in accordance with standards of acceptable community practice;
d. not primarily intended for the personal comfort or convenience of the Member, the Member's family, the Physician, or other Health Professionals;
e. approved by the appropriate medical body or health care specialty involved as effective, appropriate, and essential for the care and treatment of the Member's Condition; and
f. not Experimental or Investigational.

2.52 **Medicare** means the federal health insurance provided pursuant to Title XVIII of the Social Security Act and all amendments thereto.

2.53 **Member** means any person who meets the eligibility requirements described in this Contract and is enrolled in the Plan, and for whom the Premium prepayment required by Part VI. PREMIUMS, COPAYMENTS, COINSURANCE, DEDUCTIBLES, AND OTHER EXPENSES has been received by AvMed.

2.54 **Mental/Behavioral Health Disorder** means any disorder listed in the diagnostic categories of the most recent International Classification of Disease, or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

2.55 **Morbid Obesity (clinically severe obesity)** means a body mass index (BMI), as determined by an in-network Health Professional as of the date of service, of:

a. 40 kilograms or greater per meter squared (kg/m2); or
b. 35 kilograms or greater per meter squared (kg/m2) with an associated comorbid condition such as uncontrolled hypertension, type II diabetes, life-threatening cardiopulmonary conditions, or severe sleep apnea.

2.56 **Orthotic Appliances** or **Orthotic Devices** means any rigid or semi-rigid device needed to support a weak or deformed body part or to restrict or eliminate body movement.

2.57 **Other Health Care Facility** means any facility licensed in accordance with the laws of the appropriate legally authorized agency, other than acute care Hospitals and those facilities providing services to ventilator dependent patients, which provides inpatient services at an intermediate or lower level of care such as skilled nursing care, Residential Treatment and Rehabilitation Services.

2.58 **Out-of-Network Provider** means any Health Care Provider with whom AvMed has neither contracted nor made arrangements to render the Covered Benefits or Covered Services described in this Contract as an In-Network Provider.

2.59 **Outpatient Rehabilitation Facility** means an entity that renders, through Health Professionals licensed pursuant to Florida law (or if outside Florida, applicable state law), outpatient physical,

occupational, speech, pulmonary and cardiac rehabilitation therapies for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. The term Outpatient Rehabilitation Facility, as used herein, will not include any Hospital, including a general acute care Hospital, or any separately organized unit of a Hospital that provides comprehensive medical rehabilitation inpatient or rehabilitation outpatient services, including a Class III or Class IV "specialty rehabilitation hospital" as described in Chapter 59A, *Florida Administrative Code*.

2.60 **Pain Management** means pain assessment, medication, physical therapy, biofeedback, and counseling. Pain rehabilitation programs are programs featuring multidisciplinary services directed toward helping those with chronic pain to reduce or limit their pain.

2.61 **Partial Hospitalization** means outpatient treatment in which an individual receives at least six clinical hours of institutional care per day (24-hour period) for at least five days per week and returns home or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital will not be considered a "home" for purposes of this definition.

2.62 **Participating Provider** means any Health Care Provider with whom AvMed has contracted or made arrangements to render Covered Benefits and Covered Services to AvMed Elite Plan Members. Participating Providers are also referred to as "In-Network Providers." For a listing of AvMed Elite Plan In-Network Providers, please refer to your Provider Directory or visit our online directory at www.avmed.org.

2.63 **Physician** means any Health Professional licensed under Chapter 458 (Physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes* (or if outside Florida, applicable state law).

2.64 **Premium** means the total amount of monthly prepayment subscription charges required to be paid by the Subscribing Group to AvMed for coverage under this Contract to remain in effect. This amount does not include other out-of-pocket expenses such as Calendar Year Deductibles, Coinsurance and Copayments for Health Care Services.

2.65 **Prescription Medication** or **Prescription Drug** means a medication that is approved by the FDA and that can only be dispensed pursuant to a prescription in accordance with state and federal law. For more information, please see Part XII. PRESCRIPTION MEDICATION BENEFITS, LIMITATIONS AND EXCLUSIONS.

2.66 **Primary Care Physician (PCP)** means any Elite Plan In-Network Physician engaged in general or family practice, internal medicine, pediatrics, geriatrics, obstetrics/gynecology, or any Specialty Physician from time to time designated by AvMed as a 'Primary Care Physician' in AvMed's current list of In-Network Providers. A PCP is one who directly provides or coordinates a range of Health Care Services for a Member.

2.67 **Prior Authorization** means a decision by AvMed, prior to the time a Health Care Service is to be delivered, that the Health Care Service is a Medically Necessary Covered Service. Prior Authorization is sometimes called pre-authorization, prior approval, or pre-certification. AvMed requires you or your Health Care Provider to obtain Prior Authorization for certain services and medications before you receive them to ensure that you receive the most appropriate treatment. Prior Authorization is not a promise that AvMed will cover the cost of such services or medications.

2.68 **Prosthetic Device** means a device which replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or malfunctioning body part or organ.

2.69 **Rehabilitation Services** are Health Care Services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, injured or disabled. These services may include physical and occupational therapies, speech-language pathology, and psychiatric Rehabilitation Services in a variety of inpatient or outpatient settings.

2.70 **Residential Treatment** is a 24-hour intensive, structured, and supervised treatment program providing inpatient care but in a non-Hospital environment and is utilized for those mental health or substance use disorders that cannot be effectively treated in an outpatient or Partial Hospitalization environment.

2.71 **Retail Clinics** are a category of walk-in medical facilities located inside pharmacies, supermarkets and other retail establishments that treat uncomplicated minor illnesses and provide preventive Health Care Services, generally delivered by nurse practitioners, and often without a Physician on the premises.

2.72 **Service Area** means those counties in the State of Florida where AvMed has been approved to conduct business by the Agency for Health Care Administration (AHCA), and where Covered Benefits and Covered Services are available at the high Benefit Level from In-Network Providers to Members of the AvMed Elite Plan.

2.73 **Shared Savings Incentive** means a voluntary and optional financial incentive that a health insurer may provide to an insured for choosing certain Shoppable Health Care Services under a Shared Savings Incentive Program.

2.74 **Shoppable Health Care Service** means a lower-cost, high-quality nonemergency Health Care Service for which a Shared Savings Incentive is available for insureds under a health insurer's Shared Savings Incentive Program.

2.75 **Skilled Nursing Facility** means an institution or part thereof that is licensed as a Skilled Nursing Facility by the State of Florida (or if outside Florida, applicable state entity), and is accredited as a Skilled Nursing Facility by The Joint Commission or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare.

2.76 **Sound Natural Teeth (Tooth)** means teeth that are whole or professionally restored (restoration with amalgams, resin, or composite only); are without impairment, periodontal, or other Conditions; and are not in need of services provided for any reason other than an Accidental Dental Injury. For purposes of this Contract, a tooth previously restored with a crown inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a Sound Natural Tooth.

2.77 **Specialty Physician** means any xdddd bPhysician licensed under Chapter 458 (Physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes* (or if outside Florida, applicable state law), other than the Member's Primary Care Physician.

2.78 **Subscriber** means an employee of the Subscribing Group who meets all applicable requirements of Part III. ELIGIBILITY FOR COVERAGE, enrolls in the Plan, and for whom the Premium prepayment required by Part VI. PREMIUMS, COPAYMENTS, COINSURANCE, DEDUCTIBLES AND OTHER EXPENSES, has been received by AvMed.

2.79 **Subscribing Group** means a corporation, partnership, limited liability company, or other legal entity (and its wholly owned subsidiaries) that negotiates and agrees to contract for the Health Care Services and benefits provided herein for its eligible employees.

2.80 **Substance Dependency** means a Condition where a person's alcohol or drug use injures his health, interferes with his social or economic functioning, or causes the individual to lose self-control.

2.81 **Total Disability** means a totally disabling Condition resulting from an illness or injury that prevents a Member from engaging in any employment or occupation for which he may otherwise become qualified by reason of education, training, or experience, and for which the Member is under the regular care of a Physician.

2.82 **Urgent Care Center** means a facility licensed to provide care for minor injuries and illnesses that require immediate attention but are not severe enough for a trip to an emergency facility, including cuts, sprains, eye injuries, colds, flu, fever, insect bites, and simple fractures. For purposes of this Contract, an Urgent Care Center is not a Hospital, Skilled Nursing Facility, Outpatient Rehabilitation Facility or Retail Clinic.

2.83 **Urgent Medical Condition** means a Condition manifesting itself by acute symptoms that are of lesser severity than those recognized for an Emergency Medical Condition, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the illness or injury to place the health or safety of the Member or another individual in serious jeopardy, in the absence of medical treatment within 24 hours. Examples of Urgent Medical Conditions include high fever, dizziness, animal bites, sprains, severe pain, respiratory ailments, and infectious illnesses.

2.84 **Urgent Medical Services and Care** means medical screening, examination, and evaluation in an ambulatory setting outside of a Hospital emergency department, including an Urgent Care Center, Retail Clinic or PCP office after-hours, on a walk-in basis and usually without a scheduled appointment; and the Covered Services for those Conditions which, although not life-threatening, could result in severe injury or disability if left untreated.

2.85 **Utilization Management Programs** means those comprehensive initiatives that are designed to validate medical appropriateness, including Medical Necessity, and to coordinate Covered Services and supplies, including:

a. concurrent review of all patients hospitalized in acute care, psychiatric, rehabilitation, and Skilled Nursing Facilities, including on-site review when appropriate;

b. case management and discharge planning for all inpatients and those requiring continued care in an alternative setting (such as home care or a Skilled Nursing Facility) and for outpatients when deemed appropriate; and

c. prospective reviews for select Health Care Services to ensure that services are Medically Necessary Covered Benefits under this Contract.

2.86 **Ventilator Dependent Care Unit** means any facility, other than an acute care Hospital setting, which provides services to ventilator dependent patients including all types of facilities known as sub-acute care units, ventilator dependent units, alternative care units, sub-acute care centers and all other like facilities, whether maintained in an Independent Facility or maintained in a Hospital or Skilled Nursing Facility setting.

2.87 **Virtual Visits:**

a. Telehealth Services are live, interactive audio and visual transmissions of a Physician-patient encounter from one site to another, using telecommunications technologies and may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

b. Telemedicine Services are Health Care Services provided via telephone, the Internet, or other communications networks or devices that do not involve direct, in-person patient contact.

III. ELIGIBILITY FOR COVERAGE

Any employee, and the dependents of an employee, who meets and continues to meet the eligibility requirements described in this Contract, will be entitled to enroll in coverage under this Contract. These eligibility requirements are binding upon you and your eligible dependents. The Subscribing Group is responsible for verifying all the eligibility requirements. The Subscribing Group must notify AvMed of a change in status that would make an individual ineligible to remain covered under the terms of this Contract. AvMed has the right, at its sole discretion, to request from the Subscribing Group proof of eligibility of any individual. AvMed may also require from you and/or your eligible dependents acceptable documentation that you and/or that individual meet and continue to meet the eligibility requirements (e.g., proof of residency, copies of a court order naming the Subscriber as legal guardian, or appropriate adoption documents, as described in Part IV. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE).

3.1 **Subscriber Eligibility.** To be eligible to enroll as a Subscriber, a person must be:

a. an employee of the Subscribing Group who works the required number of hours per week as set forth in the Group Master Application for this Contract. The employee must either work or reside in the Service Area; and

b. employed for the period required for eligibility as set forth in the Group Master Application; and

c. entitled on his own behalf to participate in the medical and Hospital care benefits arranged by the Subscribing Group under this Contract.

3.2 **Dependent Eligibility.** To be eligible to enroll as a Covered Dependent, a person must be:

a. the spouse of a Subscriber under a legally valid existing marriage;

b. the Domestic Partner of a Subscriber; or

c. the child of a Subscriber, or the Subscriber's covered Domestic Partner, provided that the following conditions apply:
   i. the child is under the age of 26; and
   ii. the natural child or stepchild of the Subscriber or the Subscriber's covered Domestic Partner;
   iii. a legally adopted child in the custody of the Subscriber or the Subscriber's covered Domestic Partner;
   iv. a child for whom the Subscriber, the Subscriber's covered spouse, or covered Domestic Partner, has been appointed legal guardian pursuant to a valid court order; or
   v. the newborn child of a Covered Dependent child of the Subscriber (such coverage terminates 18 months after the birth of the newborn child).

3.3 **Qualified Medical Child Support Order (QMCSO).** In the event an eligible dependent child does not reside with the Subscriber, coverage will be extended when the Subscriber is obligated by QMCSO to provide medical care. You (or your beneficiaries) may obtain, without charge, copies of the Plan's procedures governing QMCSOs and a sample QMCSO by contacting the Plan Administrator.

3.4 **Extended Coverage for Dependent Children**

a. Dependent Children Aged 26 to 30. A dependent child who meets the following requirements may be eligible for coverage until the end of the calendar year in which the child reaches age 30, if the child:
   i. is unmarried and does not have a dependent of his own;
   ii. resides within the Service Area, or is a Full-Time or Part-Time Student; and
   iii. is not provided coverage under any other group, blanket, or franchise health insurance policy, or individual health benefits plan, or is not entitled to benefits under Medicare.

b. Continuous Coverage Requirement. If an eligible dependent child is covered under this Contract after reaching age 26, and the child's coverage is subsequently terminated before the end of the calendar year in which the child reaches age 30, the child is ineligible to be covered again under this Contract unless the child was continuously covered by other creditable coverage without a coverage gap of more than 63 days.

c. Children with Disabilities - Attainment of Limiting Age. Attainment of the limiting age by an eligible dependent child will not operate to exclude from or terminate the coverage of such child while such child is, and continues to be, both:
   i. incapable of self-sustaining employment by reason of intellectual or physical disability; and
   ii. chiefly dependent upon the Subscriber for support and maintenance.
   iii. Proof of such incapacity and dependency must be furnished to AvMed within 30 days after the date the child attains the limiting age, and subsequently as may be required by AvMed but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

d. Dependent Students on Medically Necessary Leave of Absence
   i. If an eligible dependent child is covered because they are a Full-Time or Part-Time Student at a post-secondary school, and they no longer meet the Plan's definition of Full-Time or Part-Time Student due to a Medically Necessary leave of absence, coverage may be extended until the earlier of the following:
      1) one year after the Medically Necessary leave of absence begins; or
      2) the date coverage would otherwise terminate under the Contract.
   ii. The Medically Necessary leave of absence or change in enrollment status must begin while the child is suffering from a serious illness or injury; or the leave of absence from the school must be medically certified by the child's Attending Physician; and
   iii. certification must state that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is Medically Necessary.

3.5 **Enrollment Restriction.** No person is eligible to enroll in coverage under this Contract whose AvMed coverage was previously terminated for non-payment of Premium or cause, except with AvMed's written approval.

IV. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

With respect to eligible employees and eligible dependents properly enrolled, coverage becomes effective, at 12:00 a.m. on the date shown in your Plan materials. With respect to eligible individuals who are subsequently enrolled, coverage will become effective at 12:00 a.m. on the date described in this Part. Any individual who is not properly enrolled will not be covered under this Contract. AvMed has no obligation whatsoever to any individual who is not properly enrolled.

4.1 **Open Enrollment.** During the Subscribing Group's annual open enrollment period any eligible employee, on behalf of himself and his eligible dependents, may elect to enroll in the Plan. Eligible employees and eligible dependents who enroll during the open enrollment period will be covered as Members as of the effective date of this Contract or the subsequent anniversary thereof.

4.2 **Initial Enrollment.** New employees who are eligible for coverage must enroll by submitting any application forms acceptable to or provided by AvMed, along with supporting documentation as may be required, within 30 days after the date of becoming eligible. The effective date of coverage for an eligible new employee will be the first of the month following completion of any applicable waiting period, as set forth in the Group Master Application. If the required information is not received within 30 days after the date of eligibility the new employee may not enroll until the Subscribing Group's next annual open enrollment period, or a special enrollment period if applicable.

4.3 **Special Enrollment.** Under the circumstances described below, referred to as "qualifying events," eligible employees and/or eligible dependents may request to enroll in the Plan outside of the initial and annual open enrollment periods, during a special enrollment period.

a. If an eligible employee or eligible dependents declined coverage under the Plan when it was first offered because of other group health plan or insurance coverage and that other coverage is lost due to any of the following qualifying events, the eligible employee or eligible dependents are entitled to a special enrollment period. Loss of other coverage due to an individual's failure to pay Premiums (including COBRA Premiums) on a timely basis, or termination of coverage for cause (fraud or intentional misrepresentation of material fact) will not trigger a special enrollment period.
   i. exhaustion of COBRA continuation coverage;
   ii. termination of employment or reduction in hours of employment;
   iii. termination of employer Premium contributions;
   iv. change in dependent status due to attainment of limiting age, change in legal custody or legal guardianship, divorce or annulment, or the death of an employee whose employment afforded the dependent coverage;
   v. relocation out of an HMO service area;
   vi. gaining eligibility for Premium assistance subsidy, or termination of coverage due to loss of eligibility, under Medicaid or CHIP.

b. Upon gaining a new dependent due to any of the following qualifying events, a covered employee's new dependents, or an eligible employee on behalf of himself and his new dependents, may request to enroll during the special enrollment period, providing such dependents are otherwise eligible for coverage:
   i. marriage;
   ii. Domestic Partner registration
   iii. birth;
   iv. adoption or placement for adoption; or

v. child support order or other court order (except for a court order to cover a former spouse).

4.4 **Special Enrollment Procedures**

a. A covered employee's eligible dependents, or an eligible employee on behalf of himself and his eligible dependents, must enroll by submitting any application or enrollment forms acceptable to or provided by AvMed, along with supporting documentation as we may require, within the following timeframes; otherwise, the eligible employee and/or eligible dependents must wait until the Subscribing Group's next annual open enrollment period:

i. within 30 days after the date of the loss of other coverage (proof of continuous other coverage is required);

ii. within 30 days after the date of marriage (certificate of marriage is required);

iii. within 30 days after the date of placement in the Subscriber's home for adoption, or adoption, of a child other than a newborn (proof of such placement or adoption is required);

iv. within 60 days after gaining eligibility for Premium assistance, or loss of eligibility, under Medicaid or CHIP (proof of such change in eligibility is required);

v. within 60 days after the birth of a child, including an adopted newborn child, as described below (for an adopted newborn, a copy of a written agreement to adopt, entered into by the Subscriber prior to the birth of such child, is required).

1) If notice is given within 30 days after the date of birth, no additional Premium will be charged for the newborn child's coverage during the 30-day period immediately following the newborn's birth.

2) If notice is received within 31 to 60 days after the date of birth, we will charge the applicable Premium from the date of birth. You must pay the additional Premium for coverage to be provided for the newborn child.

3) If notice is not received within 60 days after the date of birth, the child may not be enrolled until the Subscribing Group's next open enrollment period.

4.5 **Special Enrollment Effective Date of Coverage.** The effective date of any coverage provided by AvMed is dependent upon the timely receipt of any enrollment forms and supporting documentation we may require. If received within the required timeframes, coverage will become effective as described below; otherwise, a Subscriber's eligible dependents, or an eligible employee on behalf of himself and his eligible dependents, may not enroll until the Subscribing Group's next open enrollment period:

a. General Effective Date. Except as provided for newborns and adopted children (including adopted newborns), the effective date of coverage for eligible individuals properly enrolled will be the first day of the first month following receipt of the enrollment request.

b. Newborns and Adopted Newborns. The effective date of coverage for a natural newborn child properly enrolled will be the moment of birth. For an adopted newborn properly enrolled, coverage will be effective from the moment of birth if a written agreement to adopt the child was entered into by the Subscriber prior to the birth of the child. However, coverage will not be required if the child is not ultimately placed in the Subscriber's home in compliance with Chapter 63, *Florida Statutes*.

c. Adopted Children other than Newborns. The effective date of coverage for an adopted child properly enrolled, other than a newborn, will be the moment of placement in the Subscriber's home for adoption, or the date of adoption, whichever is earlier. However, coverage will not be required if the child is not ultimately placed in the Subscriber's home in compliance with Chapter 63, *Florida Statutes*.

d. Qualified Medical Child Support Order (QMCSO). If a court has ordered coverage to be provided by you for a minor child who is an eligible dependent, you must submit to us any required application or enrollment forms including a copy of the court order, along with any additional Premium due. The effective date of coverage for the eligible dependent properly enrolled will be the date of the order. You must pay the additional Premium for coverage to be provided for the eligible dependent.

V. TERMINATION

This Contract will continue in effect for one year from the effective date hereof, and may be renewed from year to year thereafter, subject to the following termination provisions. All rights to benefits under this Contract will cease at 12:00 a.m. (midnight) on the effective date of termination unless otherwise stated.

5.1 **Termination of Group Contract by Subscribing Group**

a. Termination on Anniversary Date. The Subscribing Group may terminate this Group Contract on the anniversary date by giving written notice to AvMed 15 days prior to the Contract anniversary date. In such event, benefits under this Contract will terminate for all Members on the Group Contract expiration date.

b. Early Termination. The Subscribing Group may terminate this Group Contract by giving at least 45 days' prior written notice to AvMed. In such event, benefits under this Contract will terminate for all Members on the date specified by the Subscribing Group in their written notice to AvMed and for which the Premium was paid.

5.2 **Termination of Group Contract by AvMed.** AvMed may non-renew or discontinue this Group Contract based on one or more of the conditions listed below. In such event, benefits hereunder will terminate for all Members on the Contract termination date as described.

a. Termination of Group Contract for Cause

i. *Failure to Make Premium Payment.* If the Subscribing Group fails to make payment of the monthly Premium by the Premium due date and within the grace period as provided in Part VI. PREMIUMS, COPAYMENTS, COINSURANCE, DEDUCTIBLES AND OTHER EXPENSES, coverage hereunder will terminate for all Members for whom Premium payment has not been received, on the last day for which the monthly Premium was received.

1) Coverage will remain in effect during the grace period. However, if Premium payments are not received by the end of the grace period, and AvMed has provided the Subscribing Group written notice of termination within 45 days after the Premium due date, past due payment fees may apply and AvMed may retroactively terminate the Subscribing Group's coverage.

ii. *Breach of Material Contract Provision.* If the Subscribing Group fails to comply with a material provision of the Contract that relates to rules for employer Premium contributions or group participation, termination will be effective upon 45 days' written notice from AvMed to the Subscribing Group.

iii. *Fraud/Material Misrepresentation.* If the Subscribing Group performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of this Contract, the Subscribing Group's coverage will be immediately terminated.

b. Notification by Subscribing Group Required. In the event of termination for the reasons described in paragraphs 5.2 a i. through 5.2 a iii. above, the Subscribing Group agrees to provide written notification of such termination to all its employees who are Subscribers under this Contract, and AvMed will be deemed to have complied with its notification requirements.

c. No Enrollees in Service Area. If there are no longer any enrollees in connection with the Plan who work or reside in the Service Area, termination of coverage will be effective on the last day of the month for which Premium payments were received by AvMed.

d. Discontinuation of Small Group Plans or Product

i. If we cease to offer AvMed Elite Plans for Small Groups in the Service Area, we will provide written notice to the Subscribing Group at least 90 days prior to such discontinuation.

ii. If we cease to offer any Small Group coverage in the Service Area, we will provide written notice to the Subscribing Group at least 180 days prior to such discontinuation.

e. Failure to Meet Eligibility or Participation Requirements. The Subscribing Group must meet group eligibility guidelines at each renewal period as specified in the Rate Letter (as defined in Part XVII. GENERAL PROVISIONS) to the Subscribing Group. Prior to the Subscribing Group's Contract anniversary date, AvMed will request written documentation to verify eligibility and participation requirements. Failure to timely meet such requirements, or return the appropriate

documentation, will result in the termination of this Group Contract on the Subscribing Group's anniversary date.

5.3 **Termination of a Member's Coverage**

a. Loss of Eligibility. Subject to the continuation rights described herein:

i. *Subscribers*

1) *Termination of Employment.* Upon the loss of a Subscriber's eligibility for coverage due to termination of employment, coverage for the Subscriber and the Subscriber's Covered Dependents will terminate on the last day of the Subscriber's employment, or the last day of the month for which the monthly Premium was paid and during which the Subscriber was eligible for coverage, as set forth in the Group Master Application.

2) *Other Loss of Eligibility.* Upon the loss of a Subscriber's eligibility for coverage due to a qualifying event other than termination of employment, coverage for the Subscriber and the Subscriber's Covered Dependents will terminate on the date of the qualifying event, or the last day of the month for which the monthly Premium was paid and during which the Subscriber was eligible for coverage, as set forth in the Group Master Application.

ii. *Covered Dependents*. Upon the loss of a Covered Dependent's eligibility except as described in the following paragraphs 1) and 2), coverage will terminate on the date eligibility is lost, or the last day of the month for which the monthly Premium was paid and during which the Covered Dependent was eligible for coverage, as set forth in the Group Master Application.

1) Covered Dependent children who reach age 26 and are not otherwise eligible for coverage will cease to be covered on the last day of the month during which the child turns 26.

2) Covered Dependent children who reach age 30 and are not otherwise eligible for coverage, will cease to be covered on the last day of the calendar year during which the child turns 30.

iii. *Notification Requirements – Responsibility of Subscribing Group and Subscriber*

1) The Subscribing Group shall verify that all Subscribers and Covered Dependents meet the eligibility requirements described in this Contract and are eligible to enroll. The Subscribing Group shall notify AvMed of a change in status that would make an individual ineligible to remain covered under the terms of this Contract. It is the sole responsibility of the Subscribing Group to notify AvMed in writing within 30 days after the effective date of termination regarding any Subscriber who becomes ineligible to participate in the Plan.

2) Subscribers must also notify AvMed in writing within 30 days after the date of a Covered Dependent's loss of eligibility.

3) Failure of the Subscribing Group or Subscribers to provide timely written notice may lead to retroactive termination of the Subscriber and/or Covered Dependents. The effective date for any such retroactive termination will be the last day for which the Premium was received by AvMed, and during which the Subscriber and/or Covered Dependents were eligible for coverage.

b. Termination of Coverage for Cause

i. AvMed may terminate the coverage of any Member immediately upon written notice for the following reasons which lead to a loss of Member eligibility:

1) fraud, intentional Material Misrepresentation of fact, or intentional omission in applying for membership, coverage, or benefits under this Contract. However, relative to a misstatement in the Application, after two years from the issue date, only fraudulent misstatements in the Application may be used to void the Contract or deny any Claim for a loss occurred or disability starting after the two-year period;

2) misuse of AvMed's Identification Card furnished to the Member;

3) furnishing to AvMed incorrect or incomplete information for the purpose of obtaining membership, coverage, or benefits under this Contract; or

4) behavior, which is disruptive, unruly, abusive, or uncooperative to the extent that the Member's continuing coverage under this Contract seriously impairs AvMed's ability to administer this Contract or to arrange for the delivery of Health Care Services to the Member or other Members, after AvMed has attempted to resolve the Member's problem.

5.4 **Retroactive Termination.** Retroactive adjustments in coverage will only be made for up to a 60-day period from the date of notification. In the event of retroactive termination due to the Subscribing Group's nonpayment of Premiums, or failure of the Subscribing Group or Members to timely notify AvMed of Member ineligibility, AvMed will not be responsible for Claims we incur in arranging for the provision of benefits to Members under the terms of this Contract after the effective date of such retroactive termination.

5.5 **AvMed's Obligations upon Termination.** Upon termination of your coverage for any reason, AvMed will have no further liability or responsibility to you under this Contract, except as specifically described in this Contract.

5.6 **Continuation Coverage Rights Under COBRA**

a. Introduction.

i. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

ii. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

iii. *You may have other options available to you when you lose group health coverage.* For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

b. What is COBRA continuation coverage?

i. COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay the entire cost for COBRA continuation coverage, plus a 2% administrative fee for the duration of the COBRA continuation coverage.

ii. If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

1) Your hours of employment are reduced, or

2) Your employment ends for any reason other than your gross misconduct.

iii. If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

1) Your spouse dies;
2) Your spouse's hours of employment are reduced;
3) Your spouse's employment ends for any reason other than their gross misconduct;
4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5) You become divorced or legally separated from your spouse.

iv. Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

1) The parent-employee dies;
2) The parent-employee's hours of employment are reduced;
3) The parent-employee's employment ends for any reason other than their gross misconduct;
4) The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5) The parents become divorced or legally separated; or
6) The child stops being eligible for coverage under the Plan as a "dependent child."

v. If your plan offers retiree coverage, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

c. <u>When is COBRA continuation coverage available?</u>

i. The Plan will offer COBRA continuation coverage to qualified beneficiaries after the following qualifying events:

1) The end of employment or reduction of hours of employment;
2) Death of the employee;
3) If your Plan provides retiree health coverage, the commencement of a proceeding in bankruptcy with respect to the employer; or
4) The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

ii. *For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days. You must include the Member's name, ID number and address, and the names of all qualified beneficiaries.*

d. <u>How is COBRA continuation coverage provided?</u>

i. Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

ii. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

iii. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

1) *Disability extension of 18-month period of COBRA continuation coverage.* If you or anyone in your family covered under the Plan is determined by Social Security to be

disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. The Plan Administrator must be notified before the end of the initial 18 months of COBRA coverage, and within 60 days after the date of the disability determination.

2) *Second qualifying event extension of 18-month period of continuation coverage*. If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

e. Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

f. If you have questions. Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

g. Keep your Plan informed of address changes. To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. For further information, contact the Plan Administrator.

5.7 **Continuation Coverage during Leaves of Absence**

a. Family and Medical Leaves of Absence (FMLA). Under FMLA, a Subscriber may be entitled to up to a total of 12 weeks of unpaid, job-protected leave during each calendar year for the following:

i. the birth of the Subscriber's child, to care for the newborn child, or for placement of a child in the Subscriber's home for adoption or foster care;

ii. to care for a spouse, child, or parent with a serious health condition; or

iii. for the Subscriber's own serious health condition.

iv. If the FMLA leave is paid, such pay will be reduced by the Subscriber's before-tax Premium contributions as usual for the coverage level in effect on the date FMLA leave begins. If FMLA leave is unpaid, the Subscriber will be required to pay Premium contributions directly to the employer until returning to active pay status.

v. If a Subscriber notifies the employer that he is terminating employment during FMLA leave, coverage will end on the date of notification. If the Subscriber does not return to work on the expected FMLA return date, and the employer is not notified of the intent to either

terminate employment or extend the period of leave, coverage will end on the date the Subscriber was expected to return.

vi. Plan elections may not be changed during FMLA leave unless an open enrollment occurs, or the Subscriber has a change in status event or a special enrollment event under The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

b. Military Caregiver Leave Entitlements. Subscribers who need to provide care for injured service members may also be eligible for FMLA as follows. FMLA leave for this purpose is called "military caregiver leave." Military caregiver leave allows an eligible Subscriber who is the spouse, son, daughter, parent or next of kin of a covered service member with a severe injury or illness to take up to 26 workweeks of unpaid leave during a single 12-month period to provide care for the service member. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is receiving medical treatment, recuperation, or therapy, or is in outpatient status, or is on the temporary disability retired list for a severe injury or illness.

c. Military Leaves of Absence. If a Subscriber is absent from work due to military service, continuation coverage under the Plan (including coverage for enrolled dependents) may be elected for up to 24 months from the first day of absence (or if earlier, until the day after the date the Subscriber is required to apply for or return to active employment with the employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)). The Subscriber's Premium contributions for continued coverage will be the same as for similarly situated active Members in the Plan. Whether or not coverage is continued during military service, a Subscriber may reinstate coverage under the Plan option elected on return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that any required waiting period was not completed prior to the start of the military service.

5.8 **Extension of Benefits.** In the event this Contract is terminated for any reason, except nonpayment of Premium or as set forth in this Section, such termination will be without prejudice to any continuous losses to a Member which commenced while this Contract was in force, but any extension of benefits beyond the date of termination will be predicated upon the Member's continuous Total Disability, as defined in Part II. DEFINITIONS, and will be limited to payment for the treatment of a specific accident or illness incurred while coverage under this Contract was effective.

a. The extension of benefits covered under this Contract will be limited to the occurrence of the earliest of the following events:

i. the expiration of 12 months;

ii. such time as the Member is no longer totally disabled;

iii. a succeeding carrier elects to provide replacement coverage without limitation as to the disability condition; or

iv. the maximum benefits payable under this Contract have been paid.

b. In the case of maternity coverage, when not covered by the succeeding carrier, a reasonable extension of this Contract's benefits will be provided to cover maternity expenses for a covered pregnancy that commenced while the policy was in effect. The extension will be for the period of that pregnancy only and will not be based upon Total Disability.

c. Except as provided above, no Subscriber is entitled to an extension of benefits if the termination of this Contract by AvMed is based upon one or more of the following reasons:

i. fraud or intentional misrepresentation in applying for any benefits under this Contract;

ii. disenrollment for cause; or

iii. the Subscriber has left the Service Area with the intent to work and reside outside the Service Area.

VI. PREMIUMS, COPAYMENTS, COINSURANCE, DEDUCTIBLES AND OTHER EXPENSES

This Part explains the Premium payment responsibilities of the Subscribing Group under this Contract, and Members' monetary responsibility for expenses for Covered Services received. Members are responsible and will be liable for applicable Deductibles, Copayments or Coinsurance amounts which must be paid to Health Care Providers for certain services at the time services are rendered, as shown in the Schedule of Benefits and for charges in excess of the Maximum Allowable Payment when you proactively elect to receive services from Out-of-Network Providers. In addition to the information explained in this Part, it is important that you refer to your Schedule of Benefits to determine your share of the costs for Covered Services.

6.1 Subscribing Group's Obligations

a. Monthly Premium Payment. On or before the first day of each month for which coverage is sought, Subscribing Group or its designated agent will remit to AvMed, on behalf of each Subscriber and their Covered Dependents, the monthly Premium based on the Rate Letter (as defined in Part XVII. GENERAL PROVISIONS), and the Group Master Application. Only Members for whom the stipulated payment is received by AvMed will be entitled to the Health Care Services covered under this Contract and then only for the period for which such payment is applicable.

b. Grace Period. This Contract has a 20-day grace period. This provision means that if any required Premium is not paid on or before the date it is due, it must be paid during the grace period. Acceptance of payment received after the grace period will be solely at AvMed's discretion and may be subject to past due payment fees.

   i. Coverage will remain in force during the grace period. However, if payment is not received by the last day of the grace period, and AvMed has provided the Subscribing Group written notice of termination within 45 days after the Premium due date, termination of this Contract for nonpayment of the Premium will be retroactive to 12:00 a.m. (midnight) on the last day for which the Premium was received by AvMed, unless Premium payment has otherwise been contractually adjusted and specified by the parties in a fully executed addendum to this Contract.

   ii. In the event of retroactive termination for any reason, AvMed reserves the right to recover an amount equal to the Allowed Amount or Maximum Allowable Payment for any Health Care Services provided after the effective date of such retroactive termination, less any Premiums received by us for such Member's coverage after such date. Premiums paid to AvMed by the Subscribing Group for any Member after the date on which that Member's eligibility ceased or the Member was terminated will be refunded on a pro rata basis, and limited to the total excess Premium amounts paid, less any Claims incurred after the effective date of termination.

6.2 Members' Obligations

a. Calendar Year Deductible. This amount, when applicable, must be satisfied each calendar year before AvMed's payment will begin toward Covered Services received in the same calendar year. Subject to Section 12.4, only those expenses for Covered Services submitted on Claims to AvMed will be credited toward the Calendar Year Deductible, and only up to the applicable Allowed Amount or Maximum Allowable Payment. Certain Covered Services may not be subject to the Calendar Year Deductible, as shown in your Schedule of Benefits.

   i. *Individual Calendar Year Deductible*. The Individual Calendar Year Deductible, when applicable, must be satisfied by each Member each calendar year before AvMed's payment toward Covered Services will begin during that calendar year.

   ii. *Family Calendar Year Deductible*. The Family Calendar Year Deductible, when applicable, may be satisfied by any combination of two or more family Members meeting the Family Deductible amount. The maximum amount that any one Member in a family can contribute toward the Family Calendar Year Deductible is the Individual Calendar Year Deductible. Once the Family Calendar Year Deductible has been satisfied, no other

Member in the family will have any additional Calendar Year Deductible responsibility for the remainder of that calendar year.

b. Same Calendar Year Look-Back Credit. This provision means that eligible expenses incurred by a Member while covered under the Subscribing Group's prior carrier will be credited toward satisfaction of the Calendar Year Deductible and Out-of-Pocket Maximum under this Plan if:

   i. the expenses were incurred before the effective date of this Plan but within the same calendar year; and

   ii. the expenses were applied toward satisfaction of the Deductible or Out-of-Pocket Maximum under the prior coverage before the effective date of this Plan but within the same calendar year; and

   iii. the expenses were for items or services that are Covered Benefits under this Contract. However, to receive credit, you may be required to provide AvMed written proof of what was paid from the prior carrier.

c. Copayment and Coinsurance Requirements. Covered Services rendered by certain Health Care Providers will be subject to a Copayment or Coinsurance requirement. This is the fixed dollar amount (Copayment) or percentage (Coinsurance) of the Allowed Amount or Maximum Allowable Payment you must pay when you receive these services. Please refer to your Schedule of Benefits for Covered Services that are subject to a Copayment or Coinsurance. All applicable Calendar Year Deductible, Copayment or Coinsurance amounts must be satisfied before we pay any portion of the cost for Covered Services.

d. Calendar Year Out-of-Pocket Maximum. Subject to Section 12.4, Deductible, Copayment and Coinsurance amounts paid for Covered Benefits received during the calendar year will accumulate toward the Calendar Year Out-of-Pocket Maximum. Expenses for items and services that are not, as determined by AvMed, Medically Necessary Covered Benefits or Covered Services under this Contract will not accumulate toward the Calendar Year Out-of-Pocket Maximums.

   i. *Individual Calendar Year Out-of-Pocket Maximum.* Once a Member reaches the Individual Calendar Year Out-of-Pocket Maximum amount shown in the Schedule of Benefits, we will pay for Covered Services received by that Member during the remainder of that calendar year at 100% of the Allowed Amount or Maximum Allowable Payment.

   ii. *Family Calendar Year Out-of-Pocket Maximum.* Once your family has reached the Family Calendar Year Out-of-Pocket Maximum amount shown in your Schedule of Benefits, we will pay for Covered Services received by you and your Covered Dependents during the remainder of that calendar year at 100% of the Allowed Amount or Maximum Allowable Payment. The maximum amount any one Member in a family can contribute toward the Family Calendar Year Out-of-Pocket Maximum is the Individual Calendar Year Out-of-Pocket Maximum.

6.3 **Additional Expenses You Must Pay.** In addition to your share of expenses as described above, you are responsible for the payment of charges for:

a. non-covered services;

b. Prescription Drug Brand Additional Charges;

c. expenses for Claims denied because we did not receive information requested from you regarding any other coverage and the details of such coverage; and

d. charges in excess of the Maximum Allowable Payment for Covered Services rendered by Out-of-Network Providers who have not agreed to accept our Maximum Allowable Payment as payment in full, when permitted by law. Except in the case of emergencies, a Member who proactively elects to receive services from an Out-of-Network Provider may be responsible to pay an amount that exceeds the Maximum Allowable Payment for the Health Care Services involved, in addition to the applicable Deductible and Coinsurance amounts. In such cases, fees that are in excess of allowable charges are not a Covered Benefit and therefore do not apply to your Deductible or annual out-of-pocket expense. If you proactively elect to receive services from an Out-of-Network Provider, you are responsible for filing the Claim and payment

will be made directly to you. If the provider files the Claim for you, payment will be made directly to the provider. WE RECOMMEND THAT, PRIOR TO CHOOSING AN OUT-OF-NETWORK PROVIDER FOR COVERED SERVICES, YOU CONTACT MEMBER ENGAGEMENT AT THE TELEPHONE NUMBER ON PAGE ii OF THIS CONTRACT OR ON YOUR AVMED IDENTIFICATION CARD TO OBTAIN AN ESTIMATE OF THE MAXIMUM ALLOWABLE PAYMENT SO THAT YOU ARE AWARE OF YOUR FINANCIAL RESPONSIBILITIES WITH REGARD TO THOSE SERVICES.

6.4 **Estimate of Cost For Services.** You may obtain an estimate of the cost for services from In-Network Providers by contacting AvMed's Member Engagement Center at the telephone number on page ii of this Contract or on your AvMed Identification Card. The fact that we may provide you with such information does not mean, and will not be construed to mean, that the service is a Covered Benefit. All terms and conditions of this Contract apply.

VII. PHYSICIANS, HOSPITALS AND OTHER PROVIDERS

7.1 **Provider and Service Arrangement.** AvMed is committed to arranging for comprehensive prepaid Health Care Services rendered to Members by In-Network Providers , and Out-of-Network Providers, as described in this Contract, under reasonable standards of quality health care. The professional judgment of a Physician licensed under Chapter 458 (Physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes* (or if outside Florida, applicable state law), concerning the proper course of treatment for a Member, will not be subject to modification by AvMed or its Board of Directors, Officers, or Administrators. However, this Section is not intended to, and will not, restrict any Utilization Management Program established by AvMed.

7.2 **Physician and Provider Options**

a. Within the Service Area, Members are entitled to receive Covered Services from In-Network Providers, or from Out-of-Network Providers, as described in this Contract. Within the Service Area, Covered Services from In-Network Providers will be paid at the high Benefit Level. Covered Services from Out-of-Network Providers will be paid at the low Benefit Level, except for Emergency Medical Services and Care, and services rendered by an Out-of-Network Provider as part of an AvMed authorized visit in an in-network health care facility when the Member did not proactively elect to receive such services from an Out-of-Network Provider.

b. Outside the Service Area, Members are entitled to receive Covered Services from Out-of-Network Providers, as described in this Contract. Covered Services from Out-of-Network Providers outside the Service Area will be paid at the low Benefit Level, except for Emergency Medical Services and Care.

c. Your choice of Health Professional or facility may result in lower or higher out-of-pocket expenses, and you may be required to follow certain procedures to avoid additional costs. Please remember that using In-Network Providers inside the Service Area will generally result in lower out-of-pocket expenses for you. You should always determine whether a provider is an In-Network or Out-of-Network Provider prior to receiving services. Doing so will help inform you of your out-of-pocket expenses. For more information, see Part VIII. ACCESSING COVERED BENEFITS AND SERVICES.

7.3 **Primary Care Physicians.** With the AvMed Elite Plan, Members must select a PCP upon enrollment. You can choose any PCP who is available, and accepting new patients, from the list of PCPs who are AvMed Elite Plan In-Network Providers. If you do not choose a PCP yourself, AvMed will select one for you.

a. Advantages of utilizing a PCP

i. PCPs are trained to provide a broad range of medical care. Developing and continuing a relationship with a PCP allows the Physician to become knowledgeable about you and your family's health history and act as a valuable resource to coordinate your overall healthcare needs.

ii. A PCP can help you determine when you need to visit a Specialty Physician and help you find one based on your PCP's knowledge of you and your specific healthcare needs.

iii. Care rendered by PCPs usually results in lower out-of-pocket expenses for you.

b. Selecting a PCP

i. Types of PCPs include family, general, and internal medicine practitioners, OB/GYNs who may be selected as PCPs for women, and pediatricians who may be selected as PCPs for children.

ii. You must notify AvMed of your PCP selection. Members must also notify and receive approval from AvMed prior to changing PCPs. PCP changes will become effective on the first day of the month after AvMed is notified.

7.4 **Specialty Physicians.** You are entitled to see Specialty Physicians under this AvMed Elite Plan without the requirement of a referral from your PCP.

7.5 **Provider Directory.** The names and addresses of AvMed Elite Plan In-Network Providers are set forth in a separate booklet which, by reference, is made a part of this Contract. The list of In-Network Providers, which may change from time to time, will be provided to all Subscribing Groups. The list of In-Network Providers may also be accessed from AvMed's website at www.avmed.org. In-Network Providers may from time to time cease their affiliation with AvMed. In such cases, Members may be required to receive services from another In-Network Provider. Notwithstanding the printed booklet, the names, and addresses of In-Network Providers on file with AvMed at any given time will constitute the official and controlling list of In-Network Providers. See Section 8.9 for information regarding continuity of care.

7.6 **Resident Referral to Skilled Nursing Unit or Assisted Living Facility.** If you currently reside in a continuing care facility or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, this notice applies to you. You may request to be referred to that facility's skilled nursing unit or assisted living facility. If the request for referral is denied, you may use the appeal process described in Part XIII. REVIEW PROCEDURES AND HOW TO APPEAL A CLAIM (BENEFIT) DENIAL.

7.7 **WARNING: LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED.** You should be aware that when you proactively elect to utilize the services of an Out-of-Network Provider for a covered non-emergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to the out-of-network reimbursement benefit described in this Contract. Out-of-Network Providers may bill Members for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT. In-Network Providers have agreed to accept discounted payments for Covered Services with no additional billing to you other than Coinsurance, Copayment, and Deductible amounts. You may obtain further information about the providers who have contracted with AvMed by consulting AvMed's website or contacting AvMed directly. As described in this Contract, the payment for out-of-network benefits will be the Maximum Allowable Payment.

VIII. ACCESSING COVERED BENEFITS AND SERVICES

8.1 **Covered Benefits and Covered Services.** Members are entitled to receive Covered Benefits and Covered Services only as described in this Contract, appropriately prescribed or directed by In-Network Providers and Out-of-Network Providers, in conformity with Part II. DEFINITIONS, Part IX. COVERED MEDICAL SERVICES, Part X. LIMITATIONS OF COVERED MEDICAL SERVICES, Part XI. EXCLUSIONS FROM COVERED MEDICAL SERVICES, Part XII. PRESCRIPTION MEDICATION BENEFITS, LIMITATIONS AND EXCLUSIONS, Part XVIII. PEDIATRIC DENTAL COVERAGE, LIMITATIONS AND EXCLUSIONS, and the Schedule of Benefits, which by reference is made a part of this Contract.

a. If a Member does not follow the access rules described in this Contract, he risks having the services and supplies received not covered. In such a circumstance, any payment that AvMed may make will not exceed the Maximum Allowable Payment and the Member will be responsible for reimbursing AvMed for the services and supplies received.

8.2 **Members' Responsibility in Seeking Covered Benefits and Services.** When seeking benefits under this Contract, Members are responsible for identifying themselves as Members of AvMed. Members are solely responsible for selecting a provider when obtaining Health Care Services and for verifying whether that provider is an In-Network Provider or an Out-of-Network Provider at the time Health Care Services are rendered. Members are also responsible for determining any corresponding payment options at the time the Health Care Services are rendered.

8.3 **Decision-Making for Health Care Services.** All decisions pertaining to the medical need for, or desirability of, the provision or non-provision of Health Care Services, including without limitation the most appropriate level of such services, must be made solely by the Member and their Physician in accordance with the normal patient/Physician relationship for purposes of determining what is in the best interest of the Member.

a. AvMed does not have the right of control over the medical decisions made by a Member's Physician. A Member and their treating Health Professionals are responsible for deciding what medical care should be rendered or received and when that care should be provided. AvMed is solely responsible for determining whether expenses incurred for Health Care Services are Covered Benefits or Covered Services under this Contract. In making coverage decisions, we will not be deemed to participate in or override your decisions concerning your health or the medical decisions of your Attending Physicians and other Health Professionals.

b. The ordering of a service by a Health Care Provider does not in itself make such service Medically Necessary or a Covered Service. The Subscribing Group and Members acknowledge it is possible that a Member and their treating Health Professionals may determine that such services are appropriate even though such services are not covered and will not be arranged or paid for by AvMed.

8.4 **Pre-existing condition exclusions are not applicable** under this Contract.

8.5 **Medicare Secondary Payer Provision.** If you become eligible for Medicare while covered under this Plan, please visit www.medicare.gov or contact your local Social Security office to learn about your eligibility, coverage options, enrollment periods and necessary steps to follow to ensure that you have adequate coverage. Members are urged to carefully review Part XIV. COORDINATION OF BENEFITS for more information about how this Plan works with Medicare.

8.6 **Care Management Programs**

a. We have established (and from time to time establish) various Member-focused health education and information programs as well as benefit Utilization Management Programs and utilization review programs. These voluntary programs, collectively called the Care Management Programs, are designed to:

   i. provide you with information that will help you make more informed decisions about your health;

   ii. help us facilitate the management and review of the coverage and benefits provided under our policies; and

   iii. present opportunities as explained below to mutually agree upon alternative benefits for cost-effective medically appropriate Health Care Services.

b. Please note that we reserve the right to discontinue or modify our Prior Authorization requirements and any Care Management Programs at any time without your consent.

8.7 **Concurrent Review and Discharge Planning.** We may review Hospital stays, Skilled Nursing Facility services, and other Health Care Services rendered during an inpatient stay or treatment program. We may conduct this review while you are an inpatient or after your discharge. The review is conducted solely to determine whether we should provide coverage or payment for an admission, or for Health Care Services rendered during that admission. Using our established criteria then in effect, a concurrent review of the inpatient stay may occur at regular intervals. We will provide notification to your Physician when inpatient Coverage Criteria is no longer met. In anticipation of your needs following an inpatient stay, we may provide you and your Physician with information about other Care Management Programs which may be beneficial to you, and we may help you and your Physician identify health care resources which may be available in your community. Upon

request, we will answer questions your Physician has regarding your coverage or benefits following discharge from the Hospital or Other Health Care Facility.

8.8 **Medical Necessity.** For Health Care Services to be covered under this Contract, such services must meet all of the requirements to be a Covered Benefit, including being Medically Necessary, as defined by AvMed.

a. Review of Medical Necessity. It is important to remember that any review of Medical Necessity by us is solely for the purposes of determining coverage, benefits, or payment under the terms of this Contract and not for the purpose of recommending or providing medical care. In this respect, we may review specific medical facts or information pertaining to you. Any such review, however, is strictly for the purpose of determining whether a Health Care Service provided or proposed meets the definition of Medical Necessity in this Contract, as determined by us. In applying the definition of Medical Necessity in this Contract to a specific Health Care Service, we will apply our coverage and payment guidelines then in effect. You are free to obtain a service even if we deny coverage because the service is not Medically Necessary; however, you will be solely responsible for paying for the service.

   i. Examples of hospitalization and other Health Care Services that are not Medically Necessary include:

      1) staying in the Hospital because arrangements for discharge have not been completed;

      2) staying in the Hospital because supervision in the home, or care in the home, is not available or is inconvenient; or being hospitalized for any service which could have been provided adequately in an alternate setting (e.g., Hospital outpatient department);

      3) inpatient admissions to a Hospital, Skilled Nursing Facility, or any other facility for the purpose of Custodial Care, convalescent care, or any other service primarily for the convenience of a Member, their family members, or a provider; and

      4) use of laboratory, x-ray, or other diagnostic testing that has no clear indication, or is not expected to alter your treatment.

b. Whether or not a Health Care Service is specifically listed as an Exclusion, the fact that a provider may prescribe, recommend, approve, or furnish a Health Care Service does not mean that the service is Medically Necessary (as defined by us) or a Covered Service. Please refer to Part II. DEFINITIONS for the definition of **"Medically Necessary** or **Medical Necessity."**

8.9 **Continuity of Care.** Continuity of care is the continuation of services from a terminated provider. If you are undergoing an active course of treatment by an In-Network Provider, and the provider's contract terminates for reasons other than cause, AvMed may authorize continued Medically Necessary Covered Services from that provider. Care may be continued until you select another provider, or until the next open enrollment period, whichever is longer, up to a maximum of six months after the termination of the In-Network Provider's contract. If you began prenatal care before the In-Network Provider's contract terminated, AvMed may authorize your continued care by the provider until the completion of your postpartum care. Authorization for continuity of care is dependent upon the terminated provider's agreement to render the care according to the terms of the terminated contract.

8.10 **Prior Authorization of Services**

a. If your Health Care Provider is an In-Network Provider, they will handle all authorizations, notifications, and utilization reviews with AvMed. If your Health Care Provider is an Out-of-Network Provider, you are responsible for making sure they contact AvMed to obtain Prior Authorization for a Covered Service when it is required. Please refer to your AvMed Identification Card for the telephone number where authorization may be obtained or have your Health Care Provider call 1-800-452-8633.

b. Members must remember that services provided or received without Prior Authorization from AvMed when authorization is required, are not covered except when required to treat an Emergency Medical Condition. Furthermore, if an inpatient admission is extended beyond the

number of days initially approved, without Prior Authorization for the continued stay, it may result in services not being covered. Before a service is performed, you should verify with your Health Care Provider that the service has received Prior Authorization. If you are unable to secure verification from your Health Care Provider, you may also call AvMed at 1-800-452-8633.

c. Services that require Prior Authorization from AvMed include:
   i. inpatient admissions (including Hospital and observation stays, Skilled Nursing Facilities, ventilator dependent care, acute rehabilitation and inpatient mental health or substance abuse services including Residential Treatment);
   ii. surgical procedures or services performed in an outpatient Hospital or Ambulatory Surgery Center;
   iii. complex diagnostic and therapeutic, and sub-specialty procedures (including CT, CTA, MRI, MRA, PET, and nuclear medicine) and psychological and neuropsychological testing;
   iv. Partial Hospitalization and Intensive Outpatient Treatment;
   v. Pain Management and outpatient Detoxification;
   vi. radiation oncology;
   vii. certain medications including Injectable Medications, and select medications administered in a Physician's office, an outpatient Hospital or infusion therapy setting;
   viii. Home Health Care Services;
   ix. cardiac rehabilitation;
   x. dialysis services;
   xi. transplant services;
   xii. non-emergency transport services.

d. Services requiring Prior Authorization may change from time to time. For more information about which services require Prior Authorization, contact AvMed's Member Engagement Center at 1-800-376-6651. You should always make sure your Health Care Provider contacts us to obtain Prior Authorization.

IX. COVERED MEDICAL SERVICES

The Covered Benefits or Covered Services described below may be subject to Limitations, as described in Part X. LIMITATIONS OF COVERED MEDICAL SERVICES and Exclusions as described in Part XI. EXCLUSIONS FROM COVERED MEDICAL SERVICES. Please refer to Parts X. LIMITATIONS OF COVERED MEDICAL SERVICES and XI. EXCLUSIONS FROM COVERED MEDICAL SERVICES for benefit maximums, and services that are excluded under this Contract.

9.1 Allergy Injections, Allergy Skin Testing and Treatments

9.2 Ambulance Services

a. Ambulance services provided by a local professional ground ambulance transport may be covered provided it is necessary, as determined by us, to transport you from:
   i. the place a medical emergency occurs to the nearest emergency facility appropriately staffed and equipped to provide proper care;
   ii. a Hospital which is unable to provide proper care to the nearest emergency facility appropriately staffed and equipped to provide proper care;
   iii. a Hospital to your nearest home or Skilled Nursing Facility when associated with an approved hospitalization or other confinement and your Condition requires the skill of medically trained personnel during the transport; or
   iv. a Skilled Nursing Facility to your nearest home or a Hospital when associated with an approved hospitalization or other confinement and your Condition requires the skill of medically trained personnel during transport.

b. Expenses for ambulance services by boat, airplane, or helicopter are covered under the following circumstances:

i. the pick-up point is inaccessible by ground vehicle;

ii. speed in excess of ground vehicle speed is critical; or

iii. the travel distance involved in getting you to the nearest emergency facility appropriately staffed and equipped to provide proper care is too far for medical safety by ground vehicle, as determined by us.

c. Member cost-sharing for air and water ambulance services is higher than for ground transportation.

9.3 **Ambulatory Surgery Centers.** Health Care Services rendered at Ambulatory Surgery Centers are covered and include:

a. use of operating and recovery rooms;

b. respiratory, or inhalation therapy (e.g., oxygen);

c. medications administered (except for take-home medications) at the Ambulatory Surgery Center;

d. intravenous solutions;

e. dressings, including ordinary casts;

f. anesthetics and their administration;

g. administration, including the cost, of whole blood or blood products;

h. transfusion supplies and equipment;

i. diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing (e.g., EKG); and

j. chemotherapy treatment for proven malignant disease.

9.4 **Anesthesia Administration Services.** Administration of anesthesia by a Physician or certified registered nurse anesthetist (CRNA) may be covered. In those instances where the CRNA is actively directed by a Physician other than the Physician who performed the surgical procedure, our payment for Covered Services, if any, will be made for both the CRNA and the Physician Health Care Services at the lower directed-services amount.

9.5 **Cardiac rehabilitation** means Health Care Services provided under the supervision of a Physician, or another appropriate Health Care Provider trained for cardiac therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion, or coronary bypass surgery. Cardiac rehabilitation is covered for acute myocardial infarction, percutaneous transluminal coronary angioplasty (PTCA), coronary artery bypass graft (CABG), and repair or replacement of heart valves or heart transplant. Please refer to Part X. LIMITATIONS OF COVERED MEDICAL SERVICES for applicable benefit maximums.

9.6 **Child Cleft Lip and Cleft Palate Treatment.** For treatment of a child under the age of 18 who has a cleft lip or cleft palate, Health Care Services for child cleft lip and cleft palate, including medical, dental, speech therapy, audiology, and nutrition services are covered. See also **Physical, Occupational and Speech Therapies** in Part IX. The speech therapy coverage provided herein is subject to the Limitations described in Part X. LIMITATIONS OF COVERED MEDICAL SERVICES. To be covered, the Member's Attending Physician must specifically prescribe such services and such services must be consequent to treatment of the cleft lip or cleft palate.

9.7 **Child Health Supervision Services**

a. Periodic Physician-delivered or Physician-supervised services from the moment of birth through the end of the month in which a Covered Dependent child turns 19, are covered as follows:

i. periodic examinations, which include a history, a physical examination, and a developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child;

ii. immunizations; and

iii. laboratory tests normally performed for a well-child.

b. Services must be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

9.8 **Chiropractic Services.** Office visits for the purpose of evaluation and diagnosis, diagnostic x-rays, manual manipulation of the spine to correct subluxation, and certain rehabilitative therapies when performed within the scope of the practitioner's license are covered when determined by us to be Medically Necessary. Please refer to Part X. LIMITATIONS OF COVERED MEDICAL SERVICES for applicable benefit maximums.

9.9 **Clinical Trials**

a. Routine patient care costs may be covered for Members enrolled in a qualifying clinical trial that is a Phase I, II, III, or IV clinical trial conducted for the prevention, detection, or treatment of:
   i. cancer or other life-threatening disease or Condition that is, as determined by us, likely to lead to death unless the course of the disease or Condition is interrupted;
   ii. a Phase I, II, or III clinical trial conducted for the detection or treatment of cardiovascular disease (cardiac/stroke) which is not life threatening; and
   iii. surgical musculoskeletal disorders of the spine, hip, and knees, which are not life-threatening.

b. Routine patient care costs for qualifying clinical trials include:
   i. Covered Services for which benefits are typically provided absent a clinical trial;
   ii. Covered Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
   iii. Covered Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

c. To be eligible for participation in a clinical trial, the Member's Physician must provide documentation establishing that the Member meets all inclusion criteria for the clinical trial as defined by the researcher.

d. Members are required to use an In-Network Provider for any clinical trials covered under this Contract.

e. The clinical trial must meet the following criteria:
   i. Federally funded or approved by one or more of the following:
      1) the National Institutes of Health (NIH);
      2) the Centers for Disease Control and Prevention;
      3) the Agency for Healthcare Research and Quality;
      4) the Centers for Medicare and Medicaid Services;
      5) a cooperative group or center of any of the entities listed above or the Department of Defense (DOD) or the Department of Veteran's Affairs (VA);
      6) a qualified non-governmental research entity identified in the NIH guidelines for center support grants; or
      7) the VA, DOD, or Department of Energy if the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to be both:
         a) comparable to the system of peer review of studies and investigations used by the NIH; and
         b) ensures unbiased review of the highest scientific standard by qualified individuals who have no interest in the outcome of the review.
   ii. Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration; or

iii. A drug trial that is exempt from having such an investigational new drug application.

f. In addition, the clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards before Members are enrolled in the trial. AvMed may, at any time, request documentation about the trial.

g. The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Service and is not otherwise excluded under this Contract.

9.10 **Complications of Pregnancy.** Health Care Services provided to you for the treatment of complications of pregnancy are Covered Services and will be treated the same as any other medical Condition. Complications of pregnancy include:

a. acute nephritis;

b. nephrosis;

c. cardiac decompensation;

d. eclampsia (toxemia with convulsions);

e. ectopic pregnancy;

f. uncontrolled vomiting requiring fluid replacement;

g. missed abortion (i.e., fetal death without spontaneous abortion);

h. therapeutic and missed abortion (i.e., termination of pregnancy before the time of fetal viability due to medical danger to the pregnant woman or when the pregnancy would result in the birth of an infant with grave malformation);

i. Conditions that may require other than a vaginal delivery, such as: uterine wound separation, premature labor, unresponsive to tocolytic therapy, failed trial labor, dystocia (i.e., cephalopelvic disproportion, failure to progress, dysfunctional labor), fetal distress requiring neonatal support/intervention, breech presentation where external version is unsuccessful, active clinical herpes at delivery, placenta previa, transverse lie where external version is unsuccessful, presence of fetal anomaly;

j. miscarriages;

k. medical and surgical Conditions of similar severity; and

l. Medically Necessary non-elective cesarean section.

9.11 **Dental Care**

a. Dental Care for Members over age 19 is limited to the following:

i. care and stabilization treatment rendered within 62 days of an Accidental Dental Injury provided such services are for the treatment of damage to Sound Natural Teeth;

ii. extraction of teeth when required prior to radiation therapy when you have a diagnosis of cancer of the head or neck.

b. General anesthesia and hospitalization services are covered when required to assure the safe delivery of necessary dental treatment or surgery for a dental Condition which, if left untreated, is likely to result in a medical Condition if:

i. a Member has one or more medical Conditions that would create significant or undue medical risk for the Member in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgery Center; or

ii. a Covered Dependent child is under eight years of age, and it is determined by a licensed dentist and the Covered Dependent's Attending Physician that dental treatment or surgery in a Hospital or Ambulatory Surgery Center is necessary due to a significantly complex dental Condition, or a developmental disability in which patient management in the dental office has proven to be ineffective.

c. Pediatric Dental Care is available for Covered Dependent children through the end of the month in which they turn 19. Services are available from Delta Dental PPO Providers, Delta Dental Premier Providers or Non-Delta Dental Providers. Services received from Premier or Non-Delta Dental Providers may be subject to fees in excess of the Contracted Fee, as described in

Part XVIII. PEDIATRIC DENTAL BENEFITS. Detailed information regarding pediatric dental coverage is included in Part XVIII.

9.12 **Dermatological Services.** AvMed will cover office visits to a dermatologist for Medically Necessary Covered Services, subject to the Limitations described in Part X. LIMITATIONS OF COVERED MEDICAL SERVICES. No prior referral or authorization is required for the first five visits to a dermatologist in a 12-month period for a dermatological problem.

9.13 **Diabetes Outpatient Self-Management.** All Medically Necessary equipment, supplies, and services to treat diabetes are covered. This includes outpatient self-management training and educational services if the Member's Primary Care Physician, or the Physician to whom the Member has been referred who specializes in diabetes treatment, certifies that the equipment, supplies, or services are Medically Necessary. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist.

9.14 **Diabetic Supplies.** Insulin and other covered anti-diabetic drugs and diabetic supplies, including needles, syringes, lancets, lancet devices, and test strips, are covered under your Prescription Drug benefits. Insulin pumps, when Medically Necessary and accompanied by a prescription from your Physician, are covered under your medical benefits, subject to the cost-sharing for Durable Medical Equipment shown on your Schedule of Benefits.

9.15 **Diagnosis and treatment of Autism Spectrum Disorders** through habilitative speech, occupational and physical therapy, for a Member who is (i) under 18 years of age, or (ii) 18 years of age or older and in high school, and was diagnosed at 8 years of age or younger as having a developmental disability. Services must be prescribed by the Member's Attending Physician in accordance with a treatment plan. The treatment plan required will include a diagnosis, the proposed treatment by type, the frequency and duration of treatment, the anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the Attending Physician.

9.16 **Diagnostic Services.** All prescribed diagnostic imaging, laboratory tests and services are covered when Medically Necessary and ordered by a Physician as part of the diagnosis or treatment of a covered illness or injury, or as a preventive Health Care Service. Specialized tests such as those to diagnose Conditions that cannot be diagnosed by traditional blood tests (e.g., allergy, endocrinology, genetics, and virology testing), are subject to higher Member out-of-pocket expenses.

9.17 **Diagnostic testing and treatment related to Attention Deficit Hyperactivity Disorder (ADHD)** are covered subject to Medical Necessity and utilization management guidelines. Covered Services do not include those that are primarily educational or training in nature.

9.18 **Dialysis services** including equipment, training and medical supplies are covered when provided at an in-network location, by an in-network Health Professional who is licensed to perform dialysis, including an in-network Dialysis Center. A **Dialysis Center** is an outpatient facility certified by the Centers for Medicare and Medicaid Services and the Florida Agency for Health Care Administration to provide hemodialysis and peritoneal dialysis services and support. Dialysis services require Prior Authorization.

9.19 **Drug Infusion Therapy.** Infusion therapy medications are covered as a medical benefit if administered by a Health Professional by way of intra-articular, intracavernous, intramuscular, intraocular, intrathecal, intravenous, or subcutaneous injection; or intravenous infusion. Beginning with the second treatment in a course of treatment, outpatient infusion therapy must be received in a non-Hospital setting, including a Physician's office, infusion clinic or the home. Prior Authorization may be required.

9.20 **Durable Medical Equipment (DME)**

a. Coverage includes purchase or rental, when Medically Necessary, of such DME that:

   i. can withstand repeated use (i.e., could normally be rented and used by successive patients);

ii. is primarily and customarily used to serve a medical purpose;

iii. generally, is not useful to a person in the absence of illness or injury; and

iv. is appropriate for use in a Member's home.

b. Some examples of DME are standard hospital beds, crutches, canes, walkers, wheelchairs, oxygen, respiratory equipment, apnea monitors and insulin pumps. DME does not include hearing aids or corrective lenses, dental devices, or the professional fees for fitting the same. It also does not include medical supplies and devices, such as a corset, which do not require prescriptions. AvMed will pay for rental of equipment up to the purchase price. Repair of Member owned DME, and replacement of DME solely because it is old or used, is not covered.

c. The determination of whether a covered item will be paid under the DME, orthotics or prosthetics benefits will be based upon its classification as defined by the Centers for Medicare and Medicaid Services.

9.21 **Emergency Services.** AvMed will cover all Medically Necessary Physician and Hospital services for an Emergency Medical Condition. In the event Hospital inpatient services are provided following Emergency Medical Services and Care, AvMed should be notified by the Hospital, Member, or a designee, within 24 hours of the inpatient admission if reasonably possible. AvMed may recommend and elect to transfer the Member to an in-network Hospital after the Member's Condition has been stabilized, and as soon as it is medically appropriate to do so. If the Member chooses to stay in an out-of-network Hospital after the date AvMed decides a transfer is medically appropriate, services will be paid at the low Benefit Level if the continued stay is determined to be a Covered Benefit.

a. Any Member requiring medical, Hospital or ambulance services for an Emergency Medical Condition while temporarily outside the Service Area, or within the Service Area but before they can reach an In-Network Provider, may receive the emergency benefits described in this Contract. When an Out-of-Network Provider renders services to treat an Emergency Medical Condition, any Copayment or Coinsurance amount applicable to In-Network Providers for emergency services will also apply to such Out-of-Network Provider.

b. Any request for reimbursement of payment made by a Member for services received must be filed within 90 days after the emergency or as soon as reasonably possible but not later than one year unless the Member was legally incapacitated; otherwise, such a Claim will be considered to have been waived. If Emergency Medical Services and Care are required while outside the continental United States, Alaska, or Hawaii, it is the Member's responsibility to pay for such services at the time they are received. For information on filing a Claim for such services see Part XIII. REVIEW PROCEDURES AND HOW TO APPEAL A CLAIM (BENEFIT) DENIAL.

9.22 **Habilitation Services**

a. Covered Services consist of physical, occupational and speech therapies that are provided for developmental delay, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder. Therapy services must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate state licensing board and must be furnished under the direction and supervision of a Physician or an advanced practice nurse in accordance with a written treatment plan established or certified by the Attending Physician or advanced practice nurse.

b. Covered Services must take place in a non-residential setting separate from the home or facility in which the Member lives.

c. Services are covered up to the point where no further progress can be documented. Services are not considered a Covered Benefit when measurable functional improvement is not expected, or progress has plateaued.

d. Covered Habilitation Services do not include activities or training to which the Member may be entitled under federal or state programs of public elementary or secondary education or federally aided vocational rehabilitation.

9.23 **Home Health Care Services (Skilled Home Health Care).** All Home Health Care Services require Prior Authorization.

a. The Home Health Care Services listed below are covered when the following criteria are met:

i. A Member is unable to leave home without considerable effort and the assistance of another person because the Member is:
   1) bedridden or chair bound, or restricted in ambulation whether or not assistive devices are used; or
   2) significantly limited in physical activities due to a Condition; and

ii. the Home Health Care Services rendered have been prescribed by a Physician by way of a formal written treatment plan. The written treatment plan must be reviewed and renewed by the prescribing Physician at least every 30 days until benefits are exhausted. AvMed reserves the right to request a copy of any written treatment plan to determine whether such services are covered under this Contract; and

iii. the Home Health Care Services are provided directly by (or indirectly through) a home health agency; and

iv. the Member is meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

b. Home Health Care Services are limited to:
   i. intermittent visits (i.e., up to, but not exceeding, two hours per day) for:
      1) nursing care by a registered nurse or licensed practical nurse, and home health aide services;
      2) medical social services;
      3) nutritional guidance;
      4) respiratory or inhalation therapy (e.g., oxygen); and
      5) short-term physical therapy by a physical therapist, occupational therapy by an occupational therapist, and speech therapy by a speech therapist. Such therapies provided in the home are subject to any rehabilitative outpatient physical, occupational and speech therapy visit limits.

c. Services must be consistent with a plan of treatment ordered by the Member's Physician. Nursing and home health aide services must be rendered under the supervision of a registered nurse. See Part X. LIMITATIONS OF COVERED MEDICAL SERVICES for applicable Limitations.

9.24 **Hospice Services.** Services are available for a Member whose Attending Physician has determined the Member's illness will result in a remaining life span of six months or less.

9.25 **Hospital Inpatient Care and Services.** Inpatient services received at in-network Hospitals are covered when prescribed by Physicians and pre-authorized by AvMed. Inpatient services include semi-private room and board, birthing rooms, newborn nursery care, nursing care, meals, and special diets when Medically Necessary, use of operating rooms and related facilities, the intensive care unit and services, diagnostic imaging, laboratory and other diagnostic tests, medications, biologicals, anesthesia and oxygen supplies, physical therapy, radiation therapy, respiratory therapy, and administration of blood or blood plasma. See Part IX., **Emergency Services**, for information about inpatient admission following Emergency Medical Services and Care.

9.26 **Inpatient Acute Rehabilitation Services** are covered when the following criteria are met:

a. Services must be provided under the direction of a Physician and must be provided by a Medicare-certified facility in accordance with a comprehensive rehabilitation program;

b. A plan of care must be developed and managed by a coordinated multi-disciplinary team;

c. Coverage is limited to the specific acute, catastrophic target diagnoses of severe stroke, multiple trauma, brain/spinal injury, severe neurological motor disorders and severe burns;

d. For Members in inpatient non-psychiatric or substance abuse rehabilitation facilities, the Member must be able to actively participate in at least two rehabilitative therapies and be able to tolerate at least three hours per day of skilled Rehabilitation Services for at least five (5) days a week and their Condition must be likely to result in significant improvement; and

e. The Rehabilitation Services must be required at such intensity, frequency, and duration as to make it impractical for the Member to receive services in a less intensive setting. See Part X. LIMITATIONS OF COVERED MEDICAL SERVICES for applicable benefit maximums.

9.27 **Mammograms** are covered in accordance with *Florida Statutes* and the U.S. Preventive Services Task Force (USPSTF) preventive services 'A' and 'B' recommendations**.** One baseline mammogram is covered for female Members between the ages of 35 and 39. A mammogram is available every two years for female Members between the ages of 40 and 49 and a mammogram is available every year for female Members aged 50 and older. In addition, one or more mammograms a year are available when based upon a Physician's recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister or daughter who has had breast cancer, or because a woman has not given birth before the age of 30.

9.28 **Mastectomy Surgery when Performed for Breast Cancer.** Mastectomy means the removal of all or part of the breast, when Medically Necessary for the treatment of breast cancer, as determined by a Physician.

a. Coverage for post-mastectomy reconstructive surgery will include:
   i. all stages of reconstruction of the breast on which the mastectomy has been performed;
   ii. surgery and reconstruction on the other breast to produce a symmetrical appearance; and
   iii. prostheses and treatment of physical complications during all stages of mastectomy, including lymphedemas.

b. The length of stay will not be less than that determined by the Attending Physician to be Medically Necessary in accordance with prevailing medical standards and after consultation with the Member. The Attending Physician, after consultation with the Member, may choose that outpatient care be provided at the most medically appropriate setting, which may include the Hospital, Attending Physician's office, outpatient facility, or the Member's home.

9.29 **Mental Health Services.** Inpatient, intermediate and outpatient mental health services are covered when Medically Necessary and may be covered when a Member is admitted to a Hospital or Other Health Care Facility.

a. For those disorders that cannot be effectively treated in an outpatient (including Partial Hospitalization) environment, intermediate mental health services in a Residential Treatment facility may be covered under a 24-hour intensive and structured supervised treatment program providing an inpatient level of care but in a non-Hospital environment. Treatment must be received in a facility specifically licensed as a Residential Treatment facility or Residential Treatment center by the State of Florida (or if outside Florida, applicable state law), to provide Residential Treatment programs for mental health disorders. The facility must require admission by a Physician; must have a behavioral health provider actively on duty 24 hours per day, 7 days per week; the Member must receive treatment by a psychiatrist at least once per week; and the facility's medical director must be a psychiatrist. Prior Authorization is required.

b. As an alternative to inpatient hospitalization, Partial Hospitalization may be covered under a structured program of active psychiatric treatment, provided in a Hospital outpatient setting or by a community mental health center, that is more intense than the care received in a Physician's or therapist's office. Prior Authorization is required.

c. Outpatient and Intensive Outpatient Treatment for mental health disorders may be covered when provided by a state-licensed psychiatrist or other Physician, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, Physician assistant, or other qualified mental health professional as allowed under applicable state law. Prior Authorization is required for Intensive Outpatient Treatment.

9.30 **Newborn Care.** A newborn child will be covered from the moment of birth provided that the newborn child is eligible for coverage and properly enrolled. Covered Services will consist of coverage for injury or illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, premature birth and transportation costs to the nearest

facility appropriately staffed and equipped to treat the newborn's Condition, when such transportation is Medically Necessary. Circumcisions are provided for up to one year from the date of birth.

9.31 **Nutrition Therapy.** Prescription-required nutritional supplements and low protein modified foods for use at home by a Member through age 24, may be covered when prescribed or ordered by a an In-Network Physician, only for the treatment of an inborn error of metabolism genetic disease, e.g., Disorder of Amino Acid metabolism such as phenylketonuria (PKU). Prior Authorization is required for coverage of enteral, parenteral, or oral nutrition and any related supplies. See Part X. LIMITATIONS OF COVERED MEDICAL SERVICES for applicable benefit maximums.

9.32 **Obstetrical and Gynecological Care.** An annual gynecological examination and Medically Necessary follow-up care detected at that visit are available without the need for a referral from your Primary Care Physician. You do not need Prior Authorization from AvMed or from any other person (including a PCP) to obtain access to obstetrical or gynecological care from a an in-network Health Professional who specializes in obstetrics or gynecology. The Health Professional may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of in-network Health Professionals who specialize in obstetrics or gynecology contact AvMed's Member Engagement Center or visit us online at www.avmed.org. Obstetrical care benefits as specified herein are covered and include Birthing Center care, Hospital care, anesthesia, diagnostic imaging, and laboratory services for Conditions related to pregnancy.

a. The length of a maternity stay in a Hospital will be the length determined to be Medically Necessary in compliance with Florida law and in accordance with the Newborns' and Mothers' Health Protection Act, as follows:
    i. Hospital stays of at least 48 hours following a normal vaginal delivery, or at least 96 hours following a cesarean section;
    ii. The Attending Physician does not need to obtain Prior Authorization from AvMed to prescribe a Hospital stay of this length;
    iii. AvMed will cover an extended stay if Medically Necessary; however, the Physician or Hospital must pre-certify the extended stay.
    iv. Shorter Hospital stays are permitted if the Attending Physician, in consultation with the mother, determines that to be the best course of action.
b. All covered preventive care and obstetrical services related to a pregnancy will be covered without regard to the circumstances or purpose of the pregnancy.

9.33 **Orthotic Appliances.** Coverage for Orthotic Appliances is limited to custom-made leg, arm, back and neck braces, when related to a surgical procedure or when used to avoid surgery and is necessary to perform normal activities of daily living excluding sports activities. Coverage includes the initial purchase, fitting, or adjustment. Replacements are covered only when Medically Necessary due to a change in bodily configuration. All other Orthotic Appliances are not covered. The determination of whether a covered item will be paid under the DME, orthotics or prosthetics benefits will be based upon its classification as defined by the Centers for Medicare and Medicaid Services.

9.34 **Osteoporosis diagnosis and treatment** when Medically Necessary for high-risk individuals, including estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals with vertebral abnormalities, individuals on long-term glucocorticoid (steroid) therapy, individuals with primary hyperparathyroidism and individuals with a family history of osteoporosis.

9.35 **Other Health Care Facility.** All Medically Necessary Covered Services of Other Health Care Facilities including Skilled Nursing Facilities, such as Physician visits, physiotherapy, diagnostic imaging, and laboratory work, are covered for Conditions that cannot be adequately treated with Home Health Care Services, or on an ambulatory basis, when a Member is admitted to such a facility following discharge from a Hospital. Residential Treatment facility services may be covered for mental health or substance use disorders that cannot be adequately treated on an outpatient (including Partial

Hospitalization) basis, and no prior Hospital stay is required. Services are subject to Limitations as described in Part X. LIMITATIONS OF COVERED MEDICAL SERVICES.

9.36 **Outpatient Therapeutic Services.** Covered Services for therapeutic treatments received on an outpatient basis in the home, Physician's office, Other Health Care Facility, or Hospital, including intravenous chemotherapy or other intravenous infusion therapy and Injectable Medications.

9.37 **Pain Management.** Outpatient Pain Management including pain assessment, medication, physical therapy, biofeedback, and counseling may be covered when Medically Necessary to reduce or limit chronic pain.

9.38 **Physical, Occupational and Speech Therapies**

a. Short term rehabilitative physical, occupational and speech therapies provided in an outpatient or home care setting are covered to improve or restore physical functioning following disease, injury, or loss of a body part.

b. Habilitative physical, occupational and speech therapies provided in an outpatient setting are covered when provided to help a person keep, learn, or improve skills and functioning for daily living.

c. Clinical documentation or a treatment plan to support the need for therapy services or continuing therapy must be submitted for review.

d. Continued therapy is only Medically Necessary when prescribed by a Physician to significantly improve, develop or restore physical functions that have been lost or impaired. Using additional diagnoses to obtain additional therapy for the same Condition is not considered Medically Necessary. Once maximum therapeutic benefit has been achieved, and there is no longer any progression, or a home exercise program could be used for any further gains, continuing supervised therapy is not considered Medically Necessary. Therapy for persons whose Condition is neither regressing nor improving is considered not Medically Necessary. Therapy for asymptomatic persons or in persons without an identifiable clinical Condition is considered not Medically Necessary.

e. Additional therapy can be considered for a new or separate Condition in a person who previously received therapy for another indication. An exacerbation or flare-up of a chronic illness is not considered a new incident of illness.

f. Home-based physical therapy is Medically Necessary in selected cases based upon the Member's needs, i.e., the Member must be homebound. This may be considered Medically Necessary in the transition of the Member from Hospital to home and may be an extension of case management services.

g. Services are subject to Limitations as described in Part X. LIMITATIONS OF COVERED MEDICAL SERVICES.

9.39 **Physician Care: Inpatient.** All Health Care Services rendered by Physicians and other Health Professionals when requested or directed by the Attending Physician, including surgical procedures, anesthesia, consultation, and treatment by Specialty Physicians, laboratory and diagnostic imaging services, and physical therapy are covered while the Member is admitted to a Hospital as a registered bed patient. When available and requested by the Member, the services of a CRNA licensed under Chapter 464, *Florida Statutes* (or if outside Florida, applicable state law), will be covered.

9.40 **Physician Care: Outpatient**

a. Diagnosis and Treatment. All Health Care Services rendered by Physicians and other Health Professionals are covered when Medically Necessary and when provided at in-network Medical Offices, including surgical procedures, routine hearing examinations, and vision examinations for glasses for children through the end of the month in which they turn 19 (such examinations may be provided by optometrists licensed pursuant to Chapter 463, *Florida Statutes*, or by ophthalmologists licensed pursuant to Chapter 458 or 459, *Florida Statutes*) (or if outside Florida, applicable state law), and consultation and treatment by Specialty Physicians. Also included are non-reusable materials and surgical supplies.

b. Preventive and Health Maintenance Services. Services of Health Professionals for illness prevention and health maintenance, including items or services that have an 'A' or 'B' rating in the current recommendations of the USPSTF with respect to the Member involved; immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-informed preventive care and screenings for infants, children, and adolescents as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and evidence-informed preventive care and screening for women as provided for in comprehensive guidelines supported by the HRSA. A listing of preventive health services with current 'A' or 'B' ratings is available on the USPSTF website. Important note about gender-specific preventive care benefits: Covered expenses include any recommended preventive care benefits described above that are determined by your Health Professional to be Medically Necessary, regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

9.41 **Prescription Medications.** Retail Prescription Medications may be covered when accompanied by a prescription from your Attending Physician, subject to the cost-sharing shown in your Schedule of Benefits. Certain preventive medications that have an 'A' or 'B' rating in current recommendations of the USPSTF, may be covered at no cost to you when deemed Medically Necessary and accompanied by a prescription from your Attending Physician. Coverage for insulin and other diabetic supplies is described in Part IX., under **Diabetic Supplies.** Allergy serums and chemotherapy for cancer patients are covered as described in Parts IX., and X., under **Drug Infusion Therapy**. See Part XII. PRESCRIPTION MEDICATION BENEFITS, LIMITATIONS AND EXCLUSIONS for details about your Prescription Medication coverage.

9.42 **Prosthetic Devices.** This Contract provides benefits, when Medically Necessary, for Prosthetic Devices designed to restore bodily function or replace a physical portion of the body. Coverage for Prosthetic Devices is limited to artificial limbs, artificial joints, ocular prostheses, and cochlear implants. Coverage includes the initial purchase, fitting, or adjustment. Replacement is covered only when Medically Necessary due to a change in bodily configuration. The initial Prosthetic Device following a covered mastectomy is also covered. Replacement of intraocular lenses is covered only if there is a change in prescription that cannot be accommodated by eyeglasses. All other Prosthetic Devices are not covered, including Prosthetic Devices for Deluxe, Myo-electric, and electronic Prosthetic Devices. The determination of whether a covered item will be paid under the DME, orthotics or prosthetics benefits will be based upon its classification as defined by the Centers for Medicare and Medicaid Services.

9.43 **Second Medical Opinions.** Members are entitled to a second medical opinion when disputing the appropriateness or necessity of a surgical procedure, or when subject to a serious Condition.

a. A Member may choose to obtain a second medical opinion from any In-Network or Out-of-Network Physician.

b. Once a second medical opinion has been rendered, AvMed will review and determine AvMed's obligations under this Contract, and that judgment by AvMed is controlling. Any treatment the Member obtains that is not authorized by AvMed will be at the Member's expense.

c. AvMed may limit second medical opinions in connection with a diagnosis or treatment to three per calendar year, if AvMed deems additional opinions to be an unreasonable over-utilization by the Member.

9.44 **Skilled Nursing Facilities**

a. The following Health Care Services may be Covered Services when you are a patient in a Skilled Nursing Facility:

i. room and board;

ii. respiratory or inhalation therapy (e.g., oxygen);

iii. medications and medicines administered while an inpatient (except take-home medications);

iv. intravenous solutions;

v. administration, including the cost, of whole blood or blood products;

vi. dressings, including ordinary casts;

vii. transfusion supplies and equipment;

viii. diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing (e.g., EKG);

ix. chemotherapy treatment for proven malignant disease; and

x. physical, occupational and speech therapies.

b. We reserve the right to request a treatment plan for determining coverage and payment. Services are subject to Limitations as described in Part X. LIMITATIONS OF COVERED MEDICAL SERVICES.

9.45 **Speech Therapy.** See Part IX., **Physical, Occupational and Speech Therapies**.

9.46 **Spinal Manipulation.** See Part IX., **Chiropractic Services**.

9.47 **Substance Abuse Services.** Inpatient, intermediate and outpatient substance abuse services are covered when Medically Necessary and may be covered when a Member is admitted to a Hospital or Other Health Care Facility.

a. For those disorders that cannot be effectively treated in an outpatient (including Partial Hospitalization) environment, intermediate substance abuse services in a Residential Treatment facility may be covered under a 24-hour intensive and structured supervised treatment program providing an inpatient level of care but in a non-Hospital environment. Treatment must be received in a facility specifically licensed as a Residential Treatment facility or Residential Treatment center by the State of Florida (or if outside Florida, applicable state law), to provide Residential Treatment programs for substance use disorders. The facility must require admission by a Physician, must have a behavioral health provider or an appropriately state certified professional actively on duty during the day and evening therapeutic programming, and the facility's medical director must be a Physician. For Detoxification programs in a Residential Treatment setting there must be a registered nurse onsite 24 hours per day, 7 days per week, and care must be provided under direct supervision of a Physician. Prior Authorization is required.

b. As an alternative to inpatient hospitalization, Partial Hospitalization may be covered under a structured program of active psychiatric treatment, provided in a Hospital outpatient setting or by a community mental health center, that is more intense than the care received in a Physician's or therapist's office. Prior Authorization is required.

c. Outpatient and Intensive Outpatient Treatment for substance use disorders may be covered when provided by a state-licensed psychiatrist or other Physician, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, Physician assistant, or other qualified mental health professional as allowed under applicable state law. Prior Authorization is required for Intensive Outpatient Treatment.

9.48 **Supplies.** Ostomy and urostomy supplies are covered when Medically Necessary. Items that are not medical supplies or that could be used by the Member or a family member for purposes other than ostomy care are not covered. Wound care supplies are covered when Medically Necessary as part of an approved treatment plan for treatment of a wound caused by or treated by a surgical procedure; or treatment of a wound that requires debridement. Services are subject to Limitations as described in Part X. LIMITATIONS OF COVERED MEDICAL SERVICES.

9.49 **Transplant services**, limited to the procedures listed below, are covered through AvMed's in-network Center of Excellence facilities located within the State of Florida, subject to the conditions and Limitations described in this Contract. Transplant services are subject to Prior Authorization before benefits are paid. Transplant includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation.

a. AvMed will pay benefits for services, care and treatment received or provided, only in connection with a:

i. Bone Marrow Transplant, which is specifically listed in Rule 59B-12.001, *Florida Administrative Code*, or any successor or similar rule or covered by Medicare as described in the most recently published Medicare National Coverage Determinations Manual issued by the Centers for Medicare and Medicaid Services. Coverage includes expenses associated with the donation or acquisition of an organ or tissue for the Member once the donor has been identified and has agreed to the donation. Coverage for the reasonable expenses of searching for a donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program.

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

ii. corneal transplant;

iii. heart transplant (including a ventricular assist device, if indicated, when used as a bridge to heart transplantation);

iv. heart-lung combination transplant;

v. liver transplant;

vi. kidney transplant;

vii. pancreas only transplant;

viii. pancreas transplant performed simultaneously with a kidney transplant; or

ix. lung (whole single or whole bilateral transplant).

b. We will cover donor costs and organ acquisition for transplants, other than Bone Marrow Transplants, provided such costs are not covered in whole or in part by any other carrier, organization, or person other than the donor's family or estate.

9.50 **Urgent Care Services.** All Medically Necessary Covered Services received in Urgent Care Centers, Retail Clinics, or your Primary Care Physician's office after-hours to treat an Urgent Medical Condition will be covered by AvMed. Any request for reimbursement of payment made by a Member for services received must be filed within 90 days or as soon as reasonably possible but not later than one year unless the Member was legally incapacitated. If Urgent Medical Services and Care are required while outside the continental United States, Alaska, or Hawaii, it is the Member's responsibility to pay for such services at the time they are received. For information on filing a Claim for such services, see Part XIII. REVIEW PROCEDURES AND HOW TO APPEAL A CLAIM (BENEFIT) DENIAL.

9.51 **Virtual Visits (Telehealth and Telemedicine Services)** using interactive audio, video, or other electronic media for the purpose of Physician-patient encounters for non-emergency diagnoses, consultations, and treatment. Services are available from AvMed designated Telehealth providers only.

9.52 **Vision Services (Pediatric Only).** Coverage includes one pediatric vision examination for glasses and one pair of standard eyeglass lenses and frames (from a pre-selected group of frames), or contact lenses, per calendar year for children through the end of the month in which they turn 19, as well as consultation and treatment by Specialty Physicians. Such examinations may be provided by

optometrists licensed pursuant to Chapter 463, *Florida Statutes* or by ophthalmologists licensed pursuant to Chapter 458 or 459, *Florida Statutes*, (or if outside Florida, applicable state law).

X. LIMITATIONS OF COVERED MEDICAL SERVICES

The rights of Members and obligations of In-Network Providers hereunder are subject to the following Limitations:

10.1 **Cardiac Rehabilitation.** Outpatient cardiac rehabilitation, combined with chiropractic services, outpatient pulmonary rehabilitation, and outpatient rehabilitative physical, occupational and speech therapies, is limited to 35 visits per calendar year. Cardiac rehabilitation requires Prior Authorization.

10.2 **Chiropractic services**, combined with outpatient cardiac rehabilitation, outpatient pulmonary rehabilitation, outpatient rehabilitative physical, occupational and speech therapies are limited to 35 visits per calendar year.

10.3 **Dental and Eye Exams for Children.** Routine dental exams are limited to one exam every six months for children through the end of the month in which they turn 19. See Part XVIII. PEDIATRIC DENTAL BENEFITS, LIMITATIONS AND EXCLUSIONS for additional information. Routine eye exams are limited to one visit per calendar year for children through the end of the month in which they turn 19, and one standard pair of child eyeglasses (lenses, and frames from a pre-selected group of frames).

10.4 **Dermatological Services.** Prior Authorization is required after a maximum of five visits to a dermatologist in a 12-month period for a dermatologic problem.

10.5 **Dialysis Services.** The provision of dialysis services is limited to In-Network Providers.

10.6 **Drug Infusion Therapy**

a. Provision of outpatient infusion therapy services beginning with the second treatment in a course of treatment, is limited to non-hospital settings. Services must be received in a Physician's office, infusion clinic or the Member's home.

b. Any third-party Copayment assistance (sometimes also referred to as a "copay card" or "copay coupon") provided by a drug manufacturer or any other entity to pay any applicable Calendar Year Deductible, Copayment or Coinsurance amounts for any therapy medications administered by a Health Professional will not be credited toward your Calendar Year Deductible or Calendar Year Out-of-Pocket Maximum.

10.7 **Habilitative Physical, Occupational and Speech Therapies.** Outpatient habilitative physical, occupational and speech therapies are limited to a combined maximum of 35 visits per calendar year.

10.8 **Home Health Care Services (Skilled Home Health Care).** Services are limited to 20 visits per calendar year, including:

a. intermittent visits (i.e., up to, but not exceeding, two hours per day) for:

   i. nursing care by a registered nurse or licensed practical nurse, and home health aide services;

   ii. medical social services;

   iii. nutritional guidance;

   iv. respiratory or inhalation therapy (e.g., oxygen) and;

   v. short-term physical therapy by a physical therapist, occupational therapy by an occupational therapist, and speech therapy by a speech therapist. Such therapies are subject to any rehabilitative outpatient physical, occupational and speech therapy visit limits.

b. Services must be consistent with a plan of treatment ordered by the Member's Physician. Nursing and home health aide services must be rendered under the supervision of a registered nurse.

10.9 **Hyperbaric oxygen treatments** are limited to 40 treatments per Condition as appropriate pursuant to the Centers for Medicare and Medicaid Services (CMS) guidelines and are subject to the cost-sharing shown in your Schedule of Benefits for rehabilitative physical, occupational, and speech therapies.

10.10 **Inpatient Acute Rehabilitation Hospital Services** are limited to 30 days per calendar year.

10.11 **Licensed Dietitians/Nutritionists.** Visits to licensed dietitians/nutritionists for treatment of diabetes, renal disease or obesity control are limited to three outpatient visits per calendar year.

10.12 **Nutrition Therapy.** Coverage for enteral, parenteral, or oral nutrition, and any related supplies, is limited to treatment of inborn error of metabolism genetic diseases for Members through age 24. Prior Authorization is required, and benefits are subject to additional authorization when Member cost-sharing reaches $2,500 in a calendar year.

10.13 **Orthotic Devices.** Coverage for Orthotic Devices or Orthotic Appliances is limited to custom-made leg, arm, back and neck braces when related to a surgical procedure or when used to avoid surgery and when necessary to perform normal activities of daily living, excluding sports activities. Replacements are covered only when Medically Necessary due to a change in bodily configuration.

10.14 **Other Health Care Facility.** Medically Necessary inpatient services of Other Health Care Facilities, including Skilled Nursing Facilities, are covered up to a combined maximum of 60 post-hospitalization days per calendar year, for Conditions that cannot be adequately treated with Home Health Care Services or on an ambulatory basis. Day limit does not apply to treatment of mental health and substance use disorders.

10.15 **Prosthetic Devices.** Coverage for Prosthetic Devices is limited to artificial limbs, artificial joints, ocular prostheses, and cochlear implants.

10.16 **Pulmonary Rehabilitation.** Outpatient pulmonary rehabilitation, combined with outpatient cardiac rehabilitation, chiropractic services, and outpatient rehabilitative physical, occupational and speech therapies is limited to 35 visits per calendar year. Prior Authorization is required.

10.17 **Rehabilitative Physical, Occupational and Speech Therapies.** Outpatient rehabilitative physical, occupational and speech therapies, combined with outpatient cardiac rehabilitation, chiropractic services and outpatient pulmonary rehabilitation are limited to 35 visits per calendar year, including evaluations.

10.18 **Second Medical Opinions.** AvMed may limit second medical opinions in connection with a diagnosis or treatment to three per calendar year, if AvMed deems additional opinions to be an unreasonable over-utilization by the Member.

10.19 **Skilled Nursing Facilities and Rehabilitation Centers.** See **Other Health Care Facility** above.

10.20 **Spinal Manipulation.** See **Chiropractic services** above.

10.21 **Supplies.** Provision of ostomy and urostomy supplies is limited to a one-month supply every 30 days. Coverage is limited to $2,500 per calendar year, subject to applicable Copayments and Coinsurance. Items which are not medical supplies, or which could be used by the Member or a family member for purposes other than ostomy care are not covered.

10.22 **Transplant Services.** Transplant services are limited to AvMed's in-network Center of Excellence facilities located within the State of Florida. Transportation costs for a companion to accompany the Member (or two companions when the patient is a minor) are covered only if the Member must travel greater than a 50-mile radius to receive the transplant, and are limited to $200 per day up to a $10,000 lifetime maximum.

10.23 **Ventilator dependent care** is limited to a lifetime maximum of 100 calendar days.

10.24 **Virtual Visits (Telehealth and Telemedicine Services)** are available from AvMed designated Telehealth providers only and are subject to Medical Necessity and utilization management guidelines.

XI. EXCLUSIONS FROM COVERED MEDICAL SERVICES

This Contract expressly excludes coverage and expenses for the following services. These Exclusions are in addition to any Exclusions specified in Part IX. COVERED MEDICAL SERVICES and any Limitations specified in Part X. LIMITATIONS OF COVERED MEDICAL SERVICES.

11.1 **General Exclusions include expenses for:**

a. services received prior to your coverage effective date, or after the date your coverage terminates;

b. services not within the categories described in Part IX. COVERED MEDICAL SERVICES and any amendments attached hereto, unless such services are specifically required to be covered by applicable law;

c. services which are not Medically Necessary, as defined in this Contract, and as determined by AvMed;

d. services provided by a Physician or other Health Care Provider related to you by blood or marriage;

e. services beyond the scope of practice authorized for a Health Professional under applicable state law;

f. services rendered at no charge;

g. services to diagnose or treat any Condition which initially occurred while you were (or which directly or indirectly resulted from or is connection with you being) under the influence of any chemical substance set forth in Section 877.111, *Florida Statutes*, or any substance controlled under Chapter 893, *Florida Statutes* or, with respect to such statutory provisions, any successor statutory provisions (or if outside Florida, applicable state law). Notwithstanding, this Exclusion will not apply to the use of any Prescription Medication by you if such medication is taken on the specific advice of a Physician in a manner consistent with such advice;

h. services rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group;

i. services to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with your participation in, or commission of, any act punishable by law as a misdemeanor or felony whether or not you are charged or convicted; or which constitutes riot or rebellion; or your engagement in an illegal occupation. Coverage will be available if a Member demonstrates that an injury resulted from an act of domestic violence or a Condition, whether or not the Condition was diagnosed before the occurrence of the injury.

j. any expenses for Claims denied because we did not receive information requested from you about whether or not you have other coverage (including personal injury protection motor vehicle insurance (PIP) or supplemental insurance plans) and the details of such coverage.

Additional Exclusions

11.2 **Aids or devices that assist with oral, verbal, or nonverbal communications**, including communication boards, pre-recorded speech devices, laptop computers, desktop computers, personal digital assistants, Braille typewriters, visual alert systems for the deaf, memory books, software programs and associated devices.

11.3 **Anesthesia administration services** when performed by an operating Physician or the Physician's partner or associate.

11.4 **Armed forces service-connected medical care** for both sickness and injury, including services received at military or government facilities and services received to treat an injury arising out of your service in the Armed Forces, Reserves or National Guard.

11.5 **Autopsy or postmortem examinations** and associated services, unless specifically requested by AvMed.

11.6 **Bariatric Surgery/Treatment of Morbid Obesity.** Gastric stapling, gastric bypass, gastric banding, gastric bubbles, and other procedures for the treatment of obesity or Morbid Obesity, as well as

any related evaluations or diagnostic tests. Ongoing visits for the treatment of obesity, other than establishing a program of obesity control, are also excluded.

11.7 **Breast reduction or augmentation surgery** except as required for the comprehensive treatment of breast cancer.

11.8 **Complementary or alternative medicine** including: acupuncture, aromatherapy, Ayurvedic medicine such as lifestyle modifications, purification and massage therapies, biofield therapies, bioelectromagnetic applications and medicine, biofeedback, chelation therapy, cognitive therapy, environmental medicine including the field of clinical ecology, herbal therapies, homeopathic medicine and counseling, hypnotherapy, mind-body interactions such as meditation, imagery, yoga, dance and art therapy, manual healing methods such as the Alexander technique, massage therapy, craniosacral balancing, Feldenkrais method, Hellerwork, reflexology, Rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and polarity therapy, naturopathic medicine, prayer and mental healing, Reichian therapy, Reiki, self-care and self-help training, sex therapy, SHEN therapy, sleep therapy, therapeutic touch, thermography, traditional Chinese medicine and vocational rehabilitation.

11.9 **Complications of any non-covered service**, including the evaluation, diagnosis or treatment of any Condition that arises as a complication of a non-covered service (e.g., services to treat a complication of cosmetic surgery are not covered).

11.10 **Cosmetic services** including any procedures which are undertaken primarily to improve or otherwise modify the Member's external appearance, except for reconstructive surgery to correct and repair a functional disorder as a result of a disease, injury, or congenital defect; and initial implanted prosthesis and reconstructive surgery incident to a mastectomy for cancer of the breast. Also excluded are surgical excision or reformation of any sagging skin of any part of the body, including: the eyelids, face, neck, abdomen, arms, legs, or buttocks; any services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body, including the face, lips, jaw, chin, nose, ears, breasts, or genitals (including circumcision, except newborns for up to one year from the date of birth); hair transplantation; chemical face peels or abrasion of the skin, electrolysis depilation, removal of tattooing, or any other surgical or non-surgical procedures which are primarily for cosmetic purposes or to create body symmetry. Additionally, all medical complications resulting from cosmetic surgical or non-surgical procedures are excluded.

11.11 **Counseling**, including marriage or pre-marital counseling, religious, family, career, social adjustment, pastoral, or financial counseling.

11.12 **Court-ordered services and supplies** including court-ordered care or testing, or services required as a condition of parole, probation, release or because of any legal proceeding.

11.13 **Costs** related to telephone consultations, failure to keep a scheduled appointment, or completion and preparation of any form or medical information, including requests for medical records.

11.14 **Custodial Care** and any service of a Custodial nature, including without limitation: services primarily to assist in the activities of daily living, rest homes, home companions or sitters, home parents, domestic maid services, food or home delivered meals, housing, respite care, and provision of services which are for the sole purpose of allowing a family member or caregiver of a Member to return to work.

11.15 **Dental Care for Members over age 19**, except as described under **Dental Care** in Part IX. Covered Medical Services, treatment of the teeth or their supporting structures or gums, or dental procedures, including: extraction of teeth; restoration of teeth with or without fillings, crowns or other materials; bridges; cleaning of teeth; dental implants; dentures; periodontal or endodontic procedures; orthodontic treatment (e.g., braces); intraoral Prosthetic Devices; palatal expansion devices; bruxism appliances; dental x-rays and dental services provided more than 62 days after the date of an Accidental Dental Injury regardless of whether or not such services could have been rendered within 62 days. This Exclusion also applies to services related to the diagnosis and

treatment of temporomandibular joint (TMJ) dysfunction except when Medically Necessary, and all dental treatment for TMJ.

11.16 **Dialysis services** received from providers who are not In-Network Providers.

11.17 **Durable Medical Equipment (DME)**

a. Items that are not covered include:
   i. 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;
   ii. bath related items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, handheld showers, paraffin baths, bathmats, and spas;
   iii. 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 2-person transfer), and auto tilt chairs;
   iv. electric or powered scooters; non-standard customized wheelchairs, motorized or manual;
   v. fixtures to real property, including ceiling lifts and wheelchair ramps;
   vi. car/van modifications;
   vii. air quality items: air conditioners, room humidifiers, vaporizers, air purifiers and electrostatic machines;
   viii. blood/injection related items: blood pressure cuffs, centrifuges, nova pens and needleless injectors; and
   ix. 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, emergency alert equipment, and diathermy machines.
b. Repair of Member-owned DME, and replacement of DME solely because it is old or used, is excluded.

11.18 **Educational Services.** Any service or supply for education, training or retraining services or testing including special education, remedial education; cognitive remediation; wilderness/outdoor treatment, therapy, or adventure programs (whether or not the program is part of a Residential Treatment facility or otherwise licensed institution); job training or job hardening programs; educational services and schooling or any such related or similar program including therapeutic programs within a school setting.

11.19 **Examinations.** Any health examinations needed because a third party requires the exam, including examinations to get or keep a job, examinations required under a labor agreement or other contract, to buy insurance or to get or keep a license, to travel, to go to a school, camp, sporting event, or to join in a sport or other recreational activity.

11.20 **Exercise programs**, gym memberships or exercise equipment of any kind, including exercise bicycles, treadmills, stairmasters, rowing machines, free weights, or resistance equipment. Also excluded are massage devices, portable whirlpool pumps, hot tubs, jacuzzis, sauna baths, swimming pools and similar equipment.

11.21 **Experimental or Investigational services and supplies** except as otherwise covered for Bone Marrow Transplants, pursuant to Section 59B-12.001, *Florida Administrative Code*.

11.22 **Eye Care for Members over Age 19,** including:

a. services to diagnose or treat vision problems which are not a direct consequence of trauma or prior ophthalmic surgery;
b. eye examinations; eye exercises or visual training; and
c. eyeglasses and contact lenses and their fitting.

d. In addition to the above, any surgical procedure performed primarily to correct or improve myopia or other refractive disorders (e.g., radial keratotomy, PRK and LASIK) are not covered.

e. This Exclusion does not include pediatric vision services that are covered as an Essential Health Benefit, as set forth under PPACA, Section 1302(b) of the Federal Act, for children through the end of the month in which they turn 19.

11.23 **Foot care (routine)**, including any service involving the feet or parts of the feet, in the absence of diabetes, peripheral circulatory or neurovascular disease including non-surgical treatment of bunions; flat feet; fallen arches; chronic foot strain; trimming of toenails, corns or calluses. This Exclusion does not apply to services otherwise covered under **Diabetes Outpatient Self-Management**, as described in Part IX. COVERED MEDICAL SERVICES.

11.24 **Foot supports** including orthopedic or specialty shoes, shoe build-ups, shoe orthotics, shoe braces, and shoe supports.

11.25 **Gender Transition Services.** Gender reassignment surgery and any treatment, service, supply, or medication associated with or as a result of gender reassignment or gender dysphoria are excluded; except for Members aged 18 or over who are diagnosed with gender dysphoria by an In-Network Provider, and when the recommended services are deemed Medically Necessary and all criteria under AvMed's current coverage guidelines are met. All services must be rendered by In-Network Providers to be covered. Coverage guidelines are available at www.avmed.org.

11.26 **Gene** or **Cellular Therapy Products.** Cellular therapy products include cellular immunotherapies, cancer vaccines, and other types of both autologous and allogeneic cells for certain therapeutic indications, including hematopoetic stem cells and adult and embryonic stem cells. Human gene therapy is the administration of genetic material to modify or manipulate the expression of a gene product or to alter the biological properties of living cells for therapeutic use.

11.27 **Habilitation Services.** Non-covered Habilitation Services include residential, institutional and home-based Habilitation Services, personal assistance/ attendant care services; errand services; transportation to and from training facilities unless provided by the training facility; family education and training; family support services; pre-vocational services designed to assist a Member in acquiring basic work skills; supportive employment habilitation; respite care camps; hotel respite, room and board; services that are purely educational in nature, and personal training or life coaching.

11.28 **Hearing aids** (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries, and the cost of repairs.

11.29 **Hearing examinations for Members over age 19** for the purpose of determining the need for hearing correction.

11.30 **Homemaker or domestic maid services**; sitter or companion services; services rendered by an employee or operator of an adult congregate living facility, an adult foster home, an adult day care center, or a nursing home facility.

11.31 **Home monitoring devices and measuring devices** (other than apnea monitors and Holter monitors), and any other equipment or devices for use outside the Hospital that are not covered elsewhere in this Contract.

11.32 **Hospital Services** that are associated with excluded surgery or excluded Dental Care.

11.33 **Immunizations and medications** for the purpose of foreign travel or employment.

11.34 **Infertility Diagnosis, Treatment and Supplies (Assisted Reproductive Therapy)**, including infertility evaluation, testing, diagnosis and treatment, medication, and supplies, to determine or correct the reason for infertility or inability to achieve conception. This includes artificial insemination (AI), in-vitro fertilization (IVF), ovum or embryo placement or transfer, gamete intra-fallopian transfer (GIFT), or cryogenic or other preservation techniques used in such or similar procedures.

11.35 **Mandibular and maxillary osteotomies** except when Medically Necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury.

11.36 **Medical supplies** including prefabricated splints, Thromboemboletic/support hose, and all other bandages, except as described under **Supplies** in Part IX.

11.37 **Mental Health and Substance Abuse Services** rendered in connection with a Condition not classified in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) are excluded from coverage; and services for the following categories (or equivalent terms) as listed in the most recent edition of the DSM: inpatient treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment; sexual deviations and disorders except for gender identity disorders; tobacco use disorders, except as required under USPSTF preventive care guidelines; pathological gambling, kleptomania, pyromania; inpatient stays primarily intended as a change of environment; school and/or education services, including special education, remedial education, wilderness/outdoor treatment, therapy or adventure programs (whether or not the program is part of a Residential Treatment facility or otherwise licensed institution); services provided in conjunction with school, vocation, work or recreational activities.

11.38 **Nutritional therapy** except as described under **Nutrition Therapy** in Part IX.

11.39 **Oral surgery** for Members over age 19, except as described under **Dental Care** in Part IX.

11.40 **Organ Donor Treatment and Services.** The Health Care Services and Hospital services for a donor or prospective donor who is an AvMed Member when the recipient of an organ transplant is not an AvMed Member. The reasonable costs of searching for a bone marrow donor are limited to a Member's family members and the National Bone Marrow Donor Program. Post-transplant donor complications will not be covered.

11.41 **Orthotic Devices** except as described in Part IX. COVERED MEDICAL SERVICES. Expenses for arch supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use (except for therapeutic shoes, including inserts and modifications for the treatment of severe diabetic foot disease); expenses for Orthotic Appliances or Orthotic Devices, which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding (e.g., dynamic orthotic cranioplasty or molding helmets); and expenses for devices necessary to exercise, train, or participate in sports, e.g., custom-made knee braces.

11.42 **Over-the-counter medications** and Prescription Medications not otherwise covered including hypodermic needles and syringes and self-administered Injectable Medications except insulin and insulin syringes for the treatment of diabetes as described under **Diabetic Supplies** in Part IX.

11.43 **Pain Management.** Inpatient rehabilitation for Pain Management is excluded.

11.44 **Personal comfort, hygiene or convenience items and services** deemed not Medically Necessary and not directly related to a Member's treatment, including beauty and barber services; clothing (including support hose); radio and television; guest meals and accommodations; telephone charges; take-home supplies; travel expenses (other than Medically Necessary ambulance services); motel/hotel accommodations; air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting; hot tubs, jacuzzis, heated spas, pools, or memberships to health clubs; heating pads; hot water bottles or ice packs; physical fitness equipment; and hand rails and grab bars.

11.45 **Private Duty Nursing** care or services rendered at any location.

11.46 **Prosthetic Devices** except as described in Part IX. COVERED MEDICAL SERVICES. Expenses for microprocessor controlled or myoelectric artificial limbs (e.g., C-legs); and expenses for cosmetic enhancements to artificial limbs are also not covered.

11.47 **Rehabilitation Programs.** Vocational rehabilitation, long term rehabilitation, or any other rehabilitation program.

11.48 **Rehabilitative Therapies.** Rehabilitative therapies for chronic Conditions are not covered. Therapies provided on either an inpatient or outpatient basis for the purpose of maintaining rather than improving your Condition are excluded. Maintenance therapy begins when the therapeutic goals of a treatment plan have been met or no further functional progress is expected. Services that involve non-diagnostic, non-therapeutic, routine, or repetitive procedures to maintain general welfare and do not require the skilled assistance of a licensed therapist are excluded. Therapy for abnormal speech pathology, including lisping and stuttering; rehabilitative therapy modalities that are considered investigational including cognitive therapy, Interactive Metronome Program, Augmented Soft Tissue Mobilization, Kinesio Taping/Taping, MEDEK Therapy, Hands-Free Ultrasound and Low-Frequency Sound (Infrasound), and Hivamat Therapy (Deep Oscillation Therapy) are excluded.

11.49 **Removal of benign skin lesions**, including warts, moles, skin tags, lipomas, keloids, and scars is not covered, even with a recommendation or prescription from a Physician.

11.50 **Reversal of voluntary surgically induced sterility** including the reversal of tubal ligations and vasectomies.

11.51 **Sexual Dysfunction.** All medications, devices and other forms of treatment related to a diagnosis of sexual dysfunction, regardless of etiology.

11.52 **Skilled Nursing Facilities.** Expenses for an inpatient admission to a Skilled Nursing Facility for purposes of Custodial Care, convalescent care, or any other service primarily for the convenience of you or your family members or the provider.

11.53 **Sports-related devices, services and medications** used to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.

11.54 **Supplies.** Items which are not medical supplies, or which could be used by the Member or a family member for purposes other than ostomy care are not covered.

11.55 **Surgically implanted devices and any associated external devices**, except for cardiac pacemakers, intraocular lenses, cochlear implants, artificial joints, orthopedic hardware, and vascular grafts. Dental appliances, other corrective lenses (except child eyeglasses) and hearing aids, including the professional fee for fitting them, are not covered.

11.56 **Temporomandibular Joint (TMJ) Dysfunction.** Services related to the diagnosis and treatment of TMJ except when Medically Necessary; and all dental treatment for TMJ.

11.57 **Termination of pregnancy** unless deemed Medically Necessary, subject to applicable state and federal laws.

11.58 **Training and educational programs or materials**, except as described under **Diabetes Outpatient Self-Management** in Part IX. COVERED MEDICAL SERVICES, including programs or materials for Pain Management and vocational rehabilitation.

11.59 **Transplant Services.** Expenses for the following are excluded:

a. transplant procedures excluded under this Contract (e.g., Experimental or Investigational transplant procedures);

b. transplant procedures involving the transplantation or implantation of any non-human organ or tissue;

c. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by AvMed;

d. transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ;

e. any organ, tissue, marrow, or stem cells which is/are sold rather than donated;

f. any Bone Marrow Transplant, as defined herein, which is not specifically listed in Rule 59B-12.001, *Florida Administrative Code*, or any successor or similar rule or covered by Medicare pursuant

to a national coverage decision made by CMS as evidenced in the most recently published Medicare National Coverage Determinations Manual;

g. any service in connection with the identification of a donor from a local, state, or national listing, except in the case of a Bone Marrow Transplant;

h. any non-medical costs, including temporary lodging or transportation costs for you or your family to and from the approved facility, except as described in Part X. LIMITATIONS OF COVERED MEDICAL SERVICES;

i. any artificial heart, mechanical device, or ventricular assist device (VAD) that replaces either the atrium or the ventricle;

j. collection and storage costs associated with the banking of umbilical cord blood;

k. transplant services and procedures provided by or at facilities that are not AvMed in-network Center of Excellence facilities located within the State of Florida.

11.60 **Transportation** including expenses for ambulance services to and from a Physician or Hospital except as described in Part IX. COVERED MEDICAL SERVICES and Part X. LIMITATIONS OF COVERED MEDICAL SERVICES.

11.61 **Travel or vacation expenses** even if prescribed or ordered by a Health Professional.

11.62 **Treatment in a federal, state, or governmental entity** including any care in a Hospital or Other Health Care Facility owned or operated by any federal, state, or other governmental entity unless coverage is required by applicable laws.

11.63 **Treatment, services, or supplies received outside the United States.** However, benefits will be payable for Covered Services required to treat an Emergency Medical Condition or Urgent Medical Condition arising during travel outside of the continental United States, Alaska, and Hawaii. Members are responsible for payment of such services at the time they are received and should submit the Claim to AvMed as described in Part XIII. REVIEW PROCEDURES/ AND HOW TO APPEAL A CLAIM (BENEFIT) DENIAL.

11.64 **Ventilator dependent care**, unless provided in a Ventilator Dependent Care Unit as described in Part II. DEFINITIONS.

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

11.66 **Weight Control Services.** Except those services deemed preventive and given an 'A' or 'B' rating in current recommendations by the USPSTF, any service, treatment, or program to lose, gain, or maintain weight, including and without limitation, appetite suppressants, dietary regimens, food, or food supplements (except as described under **Nutrition Therapy** in Part IX. COVERED MEDICAL SERVICES), and exercise programs or equipment, whether or not a part of a treatment plan for a Condition.

11.67 **Wigs** or cranial prostheses.

11.68 **Workers' Compensation Benefits.** Any sickness or injury for which the Member is paid benefits, or may be paid benefits if claimed, if the Member is covered or could be covered by Workers' Compensation. In addition, if the Member enters into a settlement giving up rights to recover past or future medical benefits under a Workers' Compensation law, AvMed will not cover past or future Health Care Services that are the subject of or related to that settlement. Furthermore, if the Member is covered by a Worker's Compensation program that limits benefits if other than specified Health Care Providers are used and the Member receives care or services from a Health Care Provider not specified by the program, AvMed will not cover the balance of any costs remaining after the program has paid.

XII. PRESCRIPTION MEDICATION BENEFITS, LIMITATIONS AND EXCLUSIONS

12.1 **Prescription Medication Definitions.** For the purposes of this Contract, the following terms have the meanings set forth below. See also Part II. DEFINITIONS.

a. **Brand Medication** means a Prescription Drug that is usually manufactured and sold under a name or trademark by a pharmaceutical manufacturer or a medication that is identified as a Brand Medication by AvMed. AvMed delegates the determination of Generic/Brand status to our Pharmacy Benefits Manager.

b. **Brand Additional Charge** means the additional charge that must be paid if you or your Physician choose a Brand Medication when a Generic equivalent is available. The charge is the difference between the cost of the Brand Medication and the Generic Medication. This charge must be paid in addition to the non-preferred brand cost-sharing amount. **The Brand Additional Charge does not apply toward the Calendar Year Deductible or Out-of-Pocket Maximum**.

c. **Dental-specific Medication** is medication used for dental-specific purposes including fluoride medications and medications packaged and labeled for dental-specific purposes.

d. **Formulary List** means the listing of preferred and non-preferred medications as determined by AvMed's Pharmacy and Therapeutics Committee based on the clinical efficacy, relative safety, and cost in comparison to similar medications within a therapeutic class. This multi-tiered list establishes various levels of cost-sharing for medications within therapeutic classes. As new medications become available, they may be considered excluded until AvMed's Pharmacy and Therapeutics Committee has reviewed them. Specific medications on the Formulary List and their placement in each therapeutic class are subject to change at any time without prior notice to you or your approval. It is your responsibility to consult with your Attending Physician to determine whether a medication is on the Formulary List at the time the prescription is rendered.

e. **Generic Medication** means a medication that has the same active ingredient as a Brand Medication or is identified as a Generic Medication by AvMed's Pharmacy Benefits Manager.

f. **In-Network Pharmacy** means a pharmacy (retail, mail order or specialty pharmacy) that has entered into an agreement to provide Prescription Medications to AvMed Members and has been designated as an In-Network Pharmacy. Except for emergencies, covered Prescription Medications must be obtained at In-Network Pharmacies.

g. **Maintenance Medication** is a medication that is approved by the FDA, for which the duration of therapy can reasonably be expected to exceed one year as determined by the Pharmacy Benefits Manager. Maintenance Medications are used for chronic or long-term Conditions such as asthma, cardiovascular disease, and diabetes.

h. **Specialty Medications** are high-cost FDA approved medications that are self-administered by Members. These medications may be limited in distribution to in-network specialty pharmacies. Many of these medications require Prior Authorization and are limited to a maximum 30-day supply per dispensing.

12.2 **Prescription Medication Coverage**

a. Pharmacy Coverage Criteria. Your Prescription Medication coverage includes outpatient medications (including certain contraceptives) that require a prescription, are prescribed by a Physician or other Health Professional authorized to prescribe medications within the scope of their license in accordance with AvMed's Coverage Criteria, and are filled at In-Network Pharmacies. AvMed reserves the right to make changes to Coverage Criteria for covered products and services.

b. Quantity Limits for Prescriptions. Quantity limits are set in accordance with FDA approved prescribing limitations, general practice guidelines supported by medical specialty organizations, or evidence-based, statistically valid clinical studies without published conflicting data. This means that a medication-specific quantity limit may apply to Prescription Medications that have an increased potential for over-utilization or an increased potential for a Member to experience an adverse effect at higher doses.

c. Prior Authorization and Progressive Medication Program. Your Prescription Medication coverage may require Prior Authorization, and such Prior Authorization may include the Progressive Medication Program for certain covered medications. The prescribing Physician or the In-Network Pharmacy must obtain approval (prior to dispensing) from AvMed. The list of Prescription Medications requiring Prior Authorization is subject to periodic review and modification by AvMed and may be amended without notice. A copy of the list of covered Prescription Medications, drugs requiring Prior Authorization and drugs that are a part of the Progressive Medication Program are available from AvMed's Member Engagement Center or from AvMed's website. The Progressive Medication Program encourages the use of therapeutically equivalent lower-cost medications by requiring certain medications to be utilized to treat a Condition prior to approving another medication for that Condition. The Progressive Medication Program includes the first-line use of preferred medications that are proven to be safe and effective for a given Condition and can provide the same health benefit as more expensive non-preferred medications at a lower cost.

d. Retail Prescription Medications. Your retail prescription coverage includes up to a 30-day supply of a medication for the cost-sharing amounts shown in your Schedule of Benefits. You may also obtain a 90-day supply of Maintenance Medication from a retail In-Network Pharmacy for the applicable cost-sharing per 30-day supply. Your prescription may be refilled after 75% of your previous fill has been used and subject to a maximum of 13 refills per year.

e. Mail Services for Prescriptions. Mail-order prescription coverage is a benefit option for Maintenance Medications. It is often best to get an initial prescription filled at your retail In-Network Pharmacy, then ask your Physician for an additional prescription for a 60- to 90-day refill to be ordered through mail service for the cost-sharing amount shown in your Schedule of Benefits. If the amount of medication is less than a 90-day supply, you will still be charged the mail order cost-sharing amount.

f. Obtaining Prescribed Medications. To obtain your Prescription Medication, take your prescription to, or have your Physician call, an In-Network Pharmacy. Present your prescription along with your AvMed Identification Card. Pay any applicable Calendar Year Deductible and Copayment or Coinsurance shown in your Schedule of Benefits (as well as the Brand Additional Charge if you or your Physician choose a Brand Medication when a Generic equivalent is available). Your Physician should submit prescriptions for Specialty Medications to AvMed's In-Network Specialty Pharmacy.

12.3 **Prescription Medication Limitations and Exclusions.** The following items are limited or excluded from your Prescription Medication coverage:

a. Allergy serums. However, medications administered by your Attending Physician to treat the acute phase of an illness, and chemotherapy for cancer patients, are covered in accordance with Part IX. COVERED MEDICAL SERVICES, and Part X. LIMITATIONS OF COVERED MEDICAL SERVICES, subject to cost-sharing as shown in your Schedule of Benefits.

b. Compounded prescriptions, except pediatric preparations.

c. Cosmetic products, including hair growth, skin bleaching, sun damage and anti-wrinkle medications.

d. Dental-specific Medications for dental purposes, including fluoride medications (except for children less than 5 years of age with a non-fluorinated water supply).

e. Experimental or Investigational drugs (except as required by law).

f. Fertility drugs.

g. Immunizations (except for those preventive immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention).

h. Medical supplies, including therapeutic devices, dressings, appliances, and support garments.

i. Medications and immunizations for non-business-related travel, including Transdermal Scopolamine.

j. Medications which do not require a prescription (i.e., over-the-counter medications) or when a non-prescription alternative is available, unless otherwise indicated on AvMed's Formulary List, or unless considered preventive and given an 'A' or 'B' rating in current recommendations of the United States Preventive Services Task Force (USPSTF) and accompanied by a prescription from your Attending Physician.

k. Medications not included on AvMed's Formulary List.

l. Medications or devices for the diagnosis or treatment of sexual dysfunction.

m. Nutritional supplements except as described under **Nutrition Therapy** in Part IX. COVERED MEDICAL SERVICES.

n. Prescription and non-prescription vitamins and minerals except prenatal vitamins.

o. Prescription and non-prescription appetite suppressants and products for the purpose of weight loss.

p. Replacement Prescription Drug products resulting from a lost, stolen, expired, broken, or destroyed prescription order or refill.

12.4 **Third-Party Assistance for Specialty Medications.** If you use any third-party copayment assistance (sometimes also referred to as a "copay card" or "copay coupon") provided by a drug manufacturer or any other entity to pay any applicable Deductible, Copayment or Coinsurance amounts for any Specialty Medications, you will not receive credit toward your Out-of-Pocket Maximum or Deductible for any such assistance you use.

12.5 **Prescription Medication Coverage Disclaimer.** Filling a prescription at a pharmacy is not a Claim for benefits and is not subject to the Claims and Appeals procedures under the Employee Retirement Income Security Act of 1974 (ERISA) described in Part XIII. REVIEW PROCEDURES AND HOW TO APPEAL A CLAIM (BENEFIT) DENIAL. However, any Prescription Medications that require Prior Authorization will be treated as a Claim for benefits subject to the Claims and Appeals Procedures.

XIII. REVIEW PROCEDURES AND HOW TO APPEAL A CLAIM (BENEFIT) DENIAL

13.1 **Member's Rights of Review.** Members have the right to a review of any complaint regarding the services or benefits covered under this Contract. AvMed encourages the informal resolution of complaints. If you have a complaint, you, or someone you name to act on your behalf (an authorized representative) may call AvMed's Member Engagement Center, and a Representative will try to resolve the complaint for you over the telephone. If you ask for a written response, or if the complaint is related to quality of care, we will respond in writing. The Member Engagement Center can also advise you how to name your authorized representative.

13.2 **Filing a Grievance.** If a Member's complaint cannot be resolved informally, it may be submitted to AvMed in writing. We call this 'filing a .' A Grievance is any complaint relating to Plan services, other than one that involves a request (Claim) for benefits or an appeal of an Adverse Benefit Determination. Grievances must be filed within one (1) year of the occurrence of the event or action that led to the Grievance. Grievances will be deemed to have been filed on the date received by AvMed and will be processed through AvMed's formal Member Grievance Procedures. AvMed will acknowledge and investigate the Grievance and provide a written response advising of the disposition within 60 days after receipt of the Grievance.

a. Grievances relating to Plan services may be submitted in writing to:

AvMed Member Engagement Center
P.O. Box 569008
Miami, Florida 33256-9908
Telephone: 1-800-376-6651
Fax: (305) 671-4736

b. If you are not satisfied with AvMed's final decision, you may file a written Grievance with the Department of Financial Services (DFS) within one (1) year of receipt of AvMed's final decision letter. You also have the right to contact DFS at any time to inform them of an unresolved Grievance. DFS may be contacted at the address below:

Florida Department of Financial Services
200 East Gaines Street
Tallahassee, Florida 32399
Telephone: 1-877-693-5236

13.3 **Claims for Benefits.** All Claims for benefits will be deemed to have been filed on the date received by AvMed. If a Claim is a Pre-Service or Urgent Care Claim, a Health Professional with knowledge of the Member's Condition will be permitted to act as the Member's authorized representative and will be notified of all approvals on the Member's behalf.

a. Pre-Service Claims

i. Initial Claim. AvMed will notify the Claimant of the benefit determination with respect to a Pre-Service Claim no later than 15 days after receipt of the Claim. AvMed may extend this period one time for up to 15 additional days, if we determine that such an extension is necessary due to matters beyond our control, and we notify the Claimant before the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision.

1) If such an extension is necessary because the Claimant failed to provide sufficient information to decide the Claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

2) In the case of a failure by a Claimant to follow AvMed's procedures for filing a Pre-Service Claim, the Claimant will be notified of the failure and the proper procedures to be followed, no later than five (5) days following such failure.

3) AvMed's period for making the benefit determination will be tolled from the date the notification of the extension is sent to the Claimant, until the date the Claimant responds to the request for additional information. If the Claimant fails to supply the requested information within the 45-day period, the Claim will be denied.

ii. Appeal of a Pre-Service Claim. A Claimant may appeal an Adverse Benefit Determination with respect to a Pre-Service Claim within one (1) year of receiving the Adverse Benefit Determination. AvMed will review the Claim and notify the Claimant of its determination on review, no later than 30 days after AvMed receives the Claimant's request; except in limited cases when AvMed provides new information to the Claimant that AvMed is considering in the appeal, and gives the Claimant an opportunity to respond. An appeal of an Adverse Benefit Determination with respect to a Pre-Service Claim may be submitted to:

AvMed Member Engagement Center
P.O. Box 569008
Miami, Florida 33256-9908
Telephone: 1-800-376-6651
Fax: (305) 671-4736

b. Urgent Care Claims

i. Initial Claim. Generally, the determination of whether a Claim is an Urgent Care Claim will be made by an individual acting on behalf of AvMed, applying the judgment of a prudent layperson possessing an average knowledge of health and medicine. However, if a Physician with knowledge of the Member's Condition determines that the Claim is an Urgent Care Claim, it will be deemed urgent. Urgent Care Claims may be made orally or in writing. AvMed will notify the Claimant of the benefit determination as soon as possible, considering the medical exigencies, but no later than 72 hours after receipt of the Urgent Care Claim.

1) If the Claimant fails to provide sufficient information to determine whether or to what extent benefits are covered or payable under this Contract, AvMed will notify the Claimant, no later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The Claimant will be afforded no less than 48 hours to provide the specified information.

2) AvMed will notify the Claimant of the benefit determination no later than 48 hours after the earlier of: AvMed's receipt of the specified information, or the end of the period afforded the Claimant to provide the specified information. If the Claimant fails to supply the specified information within the 48-hour period, the Claim will be denied.

3) AvMed may notify the Claimant of the benefit determination orally or in writing. If the notification is provided orally, a written or electronic notification will also be provided to the Claimant no later than three (3) days after the oral notification.

ii. Appeal of an Urgent Care Claim. A Claimant may appeal an Adverse Benefit Determination with respect to an Urgent Care Claim within one (1) year of receiving the Adverse Benefit Determination. AvMed will review the Claim and notify the Claimant of its benefit determination on review as soon as possible, considering the medical exigencies, but no later than 72 hours after receipt of the Claimant's request; except in limited cases when AvMed provides new information to the Claimant that AvMed is considering in the appeal, and gives the Claimant an opportunity to respond. An appeal of an Adverse Benefit Determination with respect to an Urgent Care Claim may be submitted to AvMed's Member Engagement Center at the address listed under Appeal of a Pre-Service Claim, above.

c. Concurrent Care Claims

i. Any reduction or termination by AvMed of Concurrent Care (other than by an amendment to this Contract or termination), before the end of an approved period or number of treatments, will constitute an Adverse Benefit Determination. In the event a Concurrent Care Claim results in an Adverse Benefit Determination, AvMed will notify the Claimant at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

1) Any request by a Claimant that relates to an Urgent Care Claim to extend the course of treatment beyond the period or number of treatments previously authorized, will be decided as soon as possible, considering the medical exigencies. AvMed will notify the Claimant of the benefit determination within 24 hours after receipt of the Claim, provided the Claim is made to AvMed at least 24 hours before the expiration of the prescribed period or number of treatments.

2) Notification and appeal of any Adverse Benefit Determination concerning a request to extend a course of treatment, whether involving an Urgent Care Claim or not, will be made in accordance with AvMed's review and notification procedures described herein.

d. Post-Service Claims

i. Initial Claim. Post-Service Claims must be submitted to AvMed within 90 days from the date of service or within one year unless the Member was legally incapacitated; otherwise, the Claim will be considered to have been waived.

1) Post-Service Claims must include all the information listed below. If a Claim is for services received to treat an Emergency Medical Condition or an Urgent Medical Condition while outside the continental United States, Alaska or Hawaii, the information must be translated into English.

a) The name of the individual who received the services;

b) The Member's name and Member ID number as they appear on the Member Identification Card;

c) The place of service and the date of service;

d) A description of the services including any applicable procedure codes;

e) The diagnosis including any applicable diagnosis codes;

f) The provider's name and address; and

g) The amount charged by the provider and a copy of the paid receipts;

2) AvMed will notify the Claimant of the benefit determination no later than 30 days after receipt of a Post-Service Claim. AvMed may extend this period one time for up to 15 additional days, if we determine such an extension is necessary due to matters beyond our control and before the expiration of the initial 30-day period, we notify the Claimant of the circumstances requiring the extension of time and the date by which we expect to render a decision.

a) If such an extension is necessary because the Claimant failed to provide sufficient information to decide the Claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

b) AvMed's period for making the benefit determination will be tolled from the date the notification of the extension is sent to the Claimant, until the date the Claimant responds to the request for additional information. If the Claimant fails to supply the requested information within the 45-day period, the Claim will be denied.

ii. Appeal of a Post-Service Claim. A Claimant may appeal an Adverse Benefit Determination with respect to a Post-Service Claim within one (1) year of receiving the Adverse Benefit Determination. AvMed will review the Claim and notify the Claimant of its determination on review, no later than 60 days after receipt of the Claimant's request; except in limited cases when AvMed provides new information to the Claimant that AvMed is considering in the appeal and gives the Claimant an opportunity to respond. An appeal of an Adverse Benefit Determination with respect to a Post-Service Claim may be submitted to AvMed's Member Engagement Center, at the address listed in Appeal of a Pre-Service Claim, above.

13.4 **Manner and Content of Initial Claims Determination Notification.** AvMed will provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification will set forth the following, in a manner calculated to be understood by the Claimant:

a. sufficient information to identify the Claim, including (as applicable) the date of service, Health Care Provider, and Claim amount, as well as notice that the diagnosis and treatment codes, along with the corresponding meaning, are available free of charge upon request;

b. the specific reason for the Adverse Benefit Determination including the denial code and its corresponding meaning;

c. reference to the specific Contract provisions on which the determination is based;

d. a description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary;

e. a description of AvMed's review procedures and the applicable time limits;

f. in the case of an Adverse Benefit Determination involving an Urgent Care Claim, a description of the expedited review process applicable to such Claim;

g. any internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination; or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

h. if the Adverse Benefit Determination is based on whether the treatment or service is Experimental or Investigational, or not Medically Necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of this Contract to the Member's medical circumstances; or a statement that such explanation will be provided free of charge upon request.

13.5 **Review Procedure upon Appeal**. In order to assure Claimants a full and fair review, AvMed's review procedures will include the following procedures and safeguards:

a. Claimants may present evidence and submit written comments, documents, records, and other information relating to a Claim.

b. upon request and free of charge, Claimants will have reasonable access to and copies of any Relevant Documents. Relevant Document means, any documentation that (i) was relied upon in making a benefit determination; (ii) was submitted, considered or generated in the course of

making a benefit determination, without regard to whether it was relied upon in making the determination; (iii) demonstrates compliance with the Plan's administrative process; and (iv) constitutes a statement of policy or guidance with respect to the Plan concerning the Adverse Benefit Determination for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the Adverse Benefit Determination.

c. the review will consider all comments, documents, records, and other information the Claimant submitted relating to the Claim, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

d. the review will be conducted by an appropriate named fiduciary of AvMed who is neither the individual who made the initial Adverse Benefit Determination nor the subordinate of such individual. Such individual will not defer to the initial Adverse Benefit Determination.

e. in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a treatment, medication, or other item is Experimental or Investigational, or not Medically Necessary, the appropriate named fiduciary will consult with a Health Professional who has appropriate training and experience in the field of medicine relevant to the medical judgment.

f. the review will provide for the identification of medical or vocational experts whose advice was obtained on behalf of AvMed in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination.

g. the review will provide that the Health Professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

h. in the case of an Urgent Care Claim, there will be an expedited review process available, pursuant to which:

   i. a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and

   ii. all necessary information, including AvMed's benefit determination on review, will be transmitted between AvMed and the Claimant by telephone, facsimile, or other available similarly expeditious methods.

13.6 **Manner and Content of Appeal Notification.** AvMed will provide a Claimant with written or electronic notification of its benefit determination upon review. In the case of an Adverse Benefit Determination, AvMed will notify both the Member and the Health Professional, and the notification will set forth all the following as appropriate, in a manner calculated to be understood by the Claimant:

a. the specific reasons for the Adverse Benefit Determination;

b. reference to the specific Contract provisions on which the Adverse Benefit Determination is based;

c. a statement that the Claimant is entitled to receive reasonable access to, and copies of, any Relevant Documents, upon request and free of charge;

d. a statement describing any voluntary appeal procedures offered by AvMed and the Claimant's right to obtain information about such procedures, and a statement of the Claimant's right to bring an action under ERISA Section 502(a) when applicable;

e. any internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination; or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

f. if the Adverse Benefit Determination is based on whether a treatment or service is Experimental or Investigational, or not Medically Necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances; or a statement that such explanation will be provided free of charge upon request.

13.7 **External Review.** In the event of a final internal Adverse Benefit Determination, a Claimant may be entitled to an external review of the Claim. This request must be submitted in writing on an External Review Request form within four (4) months of receipt of the Adverse Benefit Determination. The external reviewer will render a recommendation within 45 calendar days unless the request meets expedited criteria, in which case it will be resolved in no later than 72 hours. The external reviewer's recommendation will be binding. The external reviewer will notify the Claimant of its decision in writing, and the Plan will take action as appropriate to comply with such recommendation. For detailed information about the external review process, please contact AvMed's Member Engagement Center.

13.8 **Remedies if Process "Deemed Exhausted"**

a. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your Claim by an independent third-party, who will review the denial and issue a final decision. You may contact AvMed's Member Engagement Center at 1-800-376-6651 with any questions on your rights to external review. Please understand that if you want to be informed about the legal remedies that may be available to you and whether they are a better option for you than seeking independent external review, you should consult a lawyer of your choice. AvMed cannot provide you with legal advice. We can only explain the procedures for obtaining independent external review.

b. If this Plan is subject to ERISA, please see the Addendum to this Group Medical and Hospital Service Contract. You also have the right to seek such legal remedies as may be available to you under ERISA Section 502 or state law.

XIV. COORDINATION OF BENEFITS

14.1 **How Coordination of Benefits (COB) Works.** The services and benefits provided under this Contract are not intended to and do not duplicate any benefit to which Members are entitled under any health plan, program or policy which may be subject to COB. The amount of our payment, if any, when we coordinate benefits under this Part, is based on whether AvMed is the primary payer. When AvMed is not primary, our payment for Covered Services may be reduced so that total benefits under all your plans will not exceed 100% of the total reasonable expenses incurred for Covered Services. For purposes of this Part, in the event you receive Covered Services from an In-Network Provider, 'total reasonable expenses' will mean the amount we are obligated to pay to the provider pursuant to the applicable provider agreement we have with such provider, or if there is no such provider agreement, the amount we are obligated to pay the provider pursuant to state or federal law. When AvMed is not the primary payer, and the primary payer's payment exceeds AvMed's contracted amount, no payment will be made for such services.

14.2 **Plans Subject to COB**

a. Health plans, programs or policies which may be subject to COB include the following, which will be referred to as "plans" for purposes of this Part:

   i. any group or non-group health insurance contract, HMO contract, or other forms of group or group-type coverage whether insured or uninsured;

   ii. medical care components of long-term care contracts such as skilled nursing care, medical benefits under group or individual automobile contracts; and

   iii. Medicare or any other governmental plan as permitted by law.

14.3 **Member's Responsibilities to Avoid Duplication of Coverage.** It is your responsibility to provide us with written information about any other coverage you or your Covered Dependents may have. This information may be requested at the time of enrollment, by written correspondence annually thereafter, or in connection with a specific Health Care Service you receive. Information should be provided within 30 days of a request. Information received after one year from the date of service will not be considered. **If we do not receive the information we request from you, we may deny your Claims and you will be responsible for payment of any expenses related to such denied Claims.**

14.4 **Order of Benefit Determination.** If any covered person is eligible for services or benefits under two or more plans, any plan without a COB provision is automatically designated as the primary plan. When all applicable plans have COB provisions, the order of benefit determination will be as follows:

a. Non-Dependent or Dependent. The plan that covers the person other than as a dependent (for example, as an employee, policyholder, subscriber, or retiree) is primary to the plan which covers the person as a dependent.

   i. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, a plan covering a person as an employee or subscriber is primary; a plan of an active worker covering a person as a dependent is secondary; and Medicare is last.

b. Dependent Children Covered Under More Than One Plan

   i. *Dependent children whose parents are not separated or divorced*

      1) the plan of the parent whose birthday, excluding year of birth, falls earlier in the year will be primary; or

      2) if both parents have the same birthday, excluding year of birth, the plan that has covered the parent the longest will be primary.

   ii. *Dependent children whose parents are separated or divorced*

      1) if a parent with sole parental responsibility is not remarried, the plan of the parent with custody is primary;

      2) if a parent with sole parental responsibility has remarried, the plan of the parent with sole parental responsibility is primary; the stepparent's plan is secondary; and the plan of the parent without parental responsibility pays last; and

      3) regardless of which parent has sole parental responsibility, whenever a court order specifies that one parent is financially responsible for the child's health care expenses, the plan of that parent is primary.

c. However, if a plan subject to the birthday rule as stated above coordinates with an out-of-state plan under which the plan covering a person as a dependent of a male is primary, and those covering the person as a dependent of a female are secondary and if, as a result, the plans do not agree on the order of benefits, the provisions of the other plan will determine the order of benefits.

d. A plan covering a person as an employee who is neither laid off nor retired, or as that employee's dependent, is primary to a plan covering that person as a laid off or retired employee, or as that employee's dependent. If the other policy or plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this paragraph will not apply.

e. If none of the rules in paragraphs a. through d. above determine the order of benefits, the benefits of the plan which covered an employee or subscriber the longest will be primary.

f. If the other plan does not have rules that establish the same order of benefits as under this Contract, the benefits under the other plan will be determined primary to the benefits under this Contract.

g. If an individual is covered under a COBRA continuation plan and under another Group Health Insurance plan, the plan covering the person as an employee or as the employee's dependent will be primary to the plan covering the person as a former employee or as the former employee's dependent.

h. We will not coordinate benefits against an indemnity-type policy, an excess insurance policy, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.

14.5 **Medicare Secondary Payer Provisions.** Individuals are eligible for Medicare and can be covered under it because of age, disability, or end stage renal disease (ESRD). Individuals are also eligible for Medicare even when not covered under it if they refused it, dropped it, or did not make a proper

request for it. If you become Medicare eligible while covered under the Plan, you should visit www.medicare.gov or contact your local Social Security office to learn about your eligibility, coverage options, enrollment periods and necessary steps to follow to ensure that you have adequate coverage. When you are covered under Medicare, AvMed coordinates your benefits under this plan with the benefits Medicare pays.

a. If you are covered under Medicare due to age, have group health coverage based on you or your spouse's current employment and the employer has 20 or more employees, the group health plan is primary, and Medicare is secondary.
b. If you are eligible for Medicare due to ESRD and have group health coverage based on you or your spouse's current employment, the group health plan is primary for the first 30 months beginning with the earlier of:
    i. the month in which you became covered under Medicare Part A ESRD benefits; or
    ii. the first month in which you would have been covered under Medicare Part A ESRD benefits if a timely application had been made.
    iii. After 30 months, Medicare is primary, and the group health plan is secondary.
c. If you are covered under Medicare due to a disability other than ESRD, have group health coverage based on you or a family member's current employment and the employer has:
    i. 100 or more employees: the group health plan is primary, and Medicare is secondary;
    ii. less than 100 employees: Medicare is primary, and the group health plan is secondary.
d. If you are covered under Medicare due to age and have retiree coverage, Medicare is primary, and the group health plan (retiree coverage) is secondary.
e. If you become covered under Medicare and are still eligible and covered under a group health plan, the employer may not offer, subsidize, procure, or provide a Medicare supplement policy to you; nor may an employer persuade you to decline or terminate your coverage under the plan and elect Medicare as the primary payer.

14.6 **Right to Receive and Release Necessary Information.** For the purpose of determining the applicability and implementing the terms of the Coordination of Benefits provision of this Contract, AvMed may, without the consent of or notice to any person, plan, or organization release to or obtain from any person, plan, or organization any information, with respect to any Member or applicant for subscription, which AvMed deems to be necessary for such purposes.

14.7 **Facility of Payment.** Whenever payments which should have been made under this Plan have been made under any other plans, AvMed will have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts AvMed determines to be warranted to satisfy the intent of this provision and amounts so paid will be deemed to be benefits paid under this Plan.

14.8 **Right of Recovery.** If the amount of the payments made by AvMed is more than it should have paid under the provisions of this Part, it may recover the excess from one or more of the persons it has paid, or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Member. The 'amount of the payments made' includes the reasonable cash value of any benefits provided in the form of services.

XV. SUBROGATION AND RIGHT OF RECOVERY

15.1 **AvMed's Right of Subrogation and Recovery.** If AvMed provides health care benefits under this Contract for a Member for injuries or illness for which another party is or may be responsible, then AvMed retains the right to repayment of the full cost of all such benefits. AvMed's rights of recovery apply to any recoveries made by or on behalf of the Member from the following third-party sources, as allowed by law, including payments made by a third-party tortfeasor or any insurance company on behalf of the third-party tortfeasor; any payments or awards under an uninsured or underinsured motorist coverage policy; any worker's compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; any other payments from a source

intended to compensate a Member for injuries resulting from an accident or alleged negligence. For purposes of this Contract, a tortfeasor is any party who has committed injury, or wrongful act done willingly, negligently or in circumstances involving strict liability, but not including breach of contract for which a civil suit can be brought.

15.2 **Members Specifically Acknowledge AvMed's Right of Subrogation.** When AvMed provides health care benefits for injuries or illnesses for which a third-party is or may be responsible, AvMed will be subrogated to the Member's rights of recovery against any party to the extent of the full cost of all benefits provided by AvMed, to the fullest extent permitted by law. AvMed may proceed against any party with or without the Member's consent.

15.3 **Members Specifically Acknowledge AvMed's Right of Reimbursement.** This right of reimbursement attaches, to the fullest extent permitted by law, when AvMed has provided health care benefits for injuries or illness for which another party is or may be responsible and the Member or the Member's representative has recovered any amounts from the third party or any party making payments on the third party's behalf. By providing any benefit under this Contract, AvMed is granted an assignment of the proceeds of any settlement, judgment or other payment received by the Member to the extent of the full cost of all benefits provided by AvMed. AvMed's right of reimbursement is cumulative with and not exclusive of AvMed's subrogation right and AvMed may choose to exercise either or both rights of recovery.

15.4 **Assent for Member Notification.** Member and the Member's representatives further agree to:

a. notify AvMed promptly and in writing when notice is given to any third party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by the Member that may be the legal responsibility of a third party; and

b. cooperate with AvMed and do whatever is necessary to secure AvMed's rights of subrogation and reimbursement under this Contract; and

c. give AvMed a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from a third-party to the extent of the full cost of all benefits provided by AvMed that are associated with injuries or illness for which a third-party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement); and

d. pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due AvMed as reimbursement for the full cost of all benefits provided by AvMed that are associated with injuries or illness for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by AvMed in writing; and

e. do nothing to prejudice AvMed's rights as set forth above. This includes refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by AvMed.

15.5 **Recovery of Full Cost.** AvMed may recover the full cost of all benefits provided by AvMed under this Contract without regard to any claim of fault on the part of the Member, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from AvMed's recovery without the prior express written consent of AvMed. In the event the Member or the Member's representative fails to cooperate with AvMed, the Member will be responsible for all benefits paid by AvMed in addition to costs and attorney's fees incurred by AvMed in obtaining repayment.

XVI. DISCLAIMER OF LIABILITY AND RELATIONSHIPS BETWEEN THE PARTIES

16.1 **Indemnity of Parties**

a. Subscribing Group. Neither Subscribing Group nor its agents, servants, or employees, nor any Member is the agent or representative of AvMed, and none of them will be liable for any acts or omissions of AvMed, its agents or employees, or of an in-network Hospital or Physician, or any other person or organization with which AvMed has made or hereafter will make arrangements for the performance of services under this Contract.

b. Members. Members will not be liable to AvMed or In-Network Providers except as specifically described in this Contract, provided all procedures described in this Contract are followed.

c. AvMed. Neither AvMed nor its agents, servants or employees is the agent or representative of the Subscribing Group, and none of them will be liable for any acts or omissions of Subscribing Group, its agents or employees, or any other person representing or acting on behalf of the Subscribing Group.

16.2 **Relationship of AvMed and In-Network Providers.** AvMed does not directly employ any practicing Physicians nor any Hospital personnel or Physicians. These Health Care Providers are independent contractors and are not the agents or employees of AvMed. AvMed will be deemed not to be a Health Care Provider with respect to any services performed or rendered by any such independent contractors. In-Network Providers maintain the Physician/patient relationship with Members and are solely responsible for all Health Care Services which In-Network Providers render to Members. Therefore, AvMed will not be liable for any negligent act or omission committed by any independent practicing Physicians, nurses, or medical personnel, nor any Hospital or health care facility, its personnel, other Health Professionals or any of their employees or agents who may, from time to time, provide Health Care Services to a Member of AvMed. Furthermore, AvMed will not be vicariously liable for any negligent act or omission of any of these independent Health Professionals who treat a Member of AvMed.

16.3 **Member's Refusal of Procedures or Treatment.** Certain Members may, for personal reasons, refuse to accept procedures or treatment recommended by In-Network Physicians. Physicians may regard such refusal to accept their recommendations as incompatible with the continuance of the Physician/patient relationship and as obstructing the provision of proper medical care, and the Physician may terminate their provider relationship with the Member. If a Member refuses to accept the medical treatment or procedure recommended by the In-Network Physician and if, in the judgment of the Physician, no professionally acceptable alternative exists or if an alternative treatment does exist but is not recommended by the Physician, the Physician will advise the Member accordingly.

XVII. GENERAL PROVISIONS

17.1 **Amendment.** The terms of coverage and benefits to be provided by us may be amended annually on this Contract's anniversary date, without your consent or the consent of any other person, upon 60 days' prior written notice to the Subscribing Group. In the event the amendment is unacceptable to the Subscribing Group, the Subscribing Group may terminate this Contract upon at least 15 days' prior written notice to us. Any such amendment will be without prejudice to Claims filed with us and related to Covered Services prior to the date of such amendment. No agent or other person, except a duly authorized officer of AvMed, has the authority to modify the terms of this Contract, or to bind us in any manner not expressly described herein, including the making of any promise or representation, or by giving or receiving any information. The terms of coverage and benefits to be provided by us may not be amended by the Subscribing Group unless such amendment is evidenced in writing and signed by a duly authorized officer of AvMed.

17.2 **Assignment and Delegation.** Your rights and obligations arising hereunder may not be assigned, delegated, or otherwise transferred by you without our written consent. We may assign our rights and coverage, or benefit obligations to our successor in interest or an affiliated entity without your consent at any time. Any assignment, delegation, or transfer made in violation of this provision will be void.

17.3 **Circumstances Not Reasonably Within the Control of AvMed.** In the event of circumstances not reasonably within the control of AvMed, including major disasters and under such circumstances as complete or partial destruction of facilities, an act of God, war, riot, civil insurrection, disability of a significant part of a Hospital or in-network medical personnel or similar causes, if the rendition of Health Care Services and Hospital services provided under this Contract is delayed or rendered impractical, neither AvMed, In-Network Providers, nor any Physician will have any liability or

obligation on account of such delay or failure to provide services; however, AvMed will make a good faith effort to arrange for the timely provision of Covered Services during such event.

17.4 **Clerical Errors.** Clerical errors will neither deprive any individual Member of any benefits or coverage provided under this Group Contract nor will such errors act as authorization of benefits or coverage for the Member that is not otherwise validly in force.

17.5 **Compliance with Law.** The terms of coverage and benefits to be provided by us under this Contract will be deemed to have been modified by the parties and will be interpreted so as to comply with applicable State of Florida and United States laws and regulations dealing with rates, benefits, eligibility, enrollment, termination, conversion, or other rights and duties of you, or AvMed.

17.6 **Confidentiality**

a. Except as otherwise specifically provided in this Contract, and except as may be required for us to administer coverage and benefits, specific medical information concerning you, received by providers, will be kept confidential by us in conformity with applicable law. Such information may be disclosed to third parties for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and benefits, specifically including our quality assurance and Care Management Programs. Additionally, we may disclose such information to entities affiliated with us or other persons or entities we utilize to assist in providing coverage, benefits, or services under this Contract. Further, any documents or information properly subpoenaed in a judicial proceeding, or by order of a regulatory agency, will not be subject to this provision.

b. Our arrangements with a provider may require that we release certain Claims and medical information about persons covered under this Contract to that provider even if treatment has not been sought by or through that provider. By accepting coverage, you hereby authorize us to release to providers Claims information, including related medical information, pertaining to you in order for any such provider to evaluate your financial responsibility under this Contract.

17.7 **Contracting Parties.** By executing this Contract, Subscribing Group and AvMed agree to make the Health Care Services and Hospital services specified herein available to persons who are eligible under the provisions of Part III. ELIGIBILITY FOR COVERAGE. Subscribing Group hereby represents that it has met the non-discrimination testing requirements under *U.S. Code* Section 105(h). The delivery of benefits and services covered in this Contract will be subject to the provisions, Limitations and Exclusions described in this Contract and any amendments, modifications and Contract termination provisions specified herein, and by the mutual agreement between AvMed and Subscribing Group, without the consent or concurrence of the Members. By electing or accepting Health Care Services and Hospital or other benefits hereunder, all Members legally capable of contracting and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

17.8 **Contract Review by Subscribing Group.** The Subscribing Group may, if this Contract is not satisfactory for any reason, return this Contract within three days after receipt and receive a full refund of the deposit paid, if any, unless the services of AvMed were utilized during the three days. If this Contract is not returned within three days after receipt, then this Contract will be deemed to have been accepted.

17.9 **Cooperation Required of You and Your Covered Dependents.** You must cooperate with us, and must execute and submit to us any consents, releases, assignments, and other documents we may request in order to administer and exercise our rights hereunder. Failure to do so may result in the denial of Claims and will constitute grounds for termination of coverage for cause, by us, as set forth in Part V. TERMINATION.

17.10 **Eligibility Requirements Control.** The eligibility requirements described in this Contract are controlling and no coverage to the contrary will be effective. Coverage will not be implied due to clerical or administrative errors if such coverage were contrary to Part III.

17.11 **Entire Agreement.** This Contract, including the Application and any enrollment forms, schedules, and amendments, sets forth the exclusive and entire understanding and agreement between you

and AvMed and will be binding upon the Subscribing Group, all Members, AvMed, and any of their subsidiaries, affiliates, successors, heirs, and permitted assignees. All prior negotiations, agreements, and understandings are thus superseded.

17.12 **Evidence of Coverage.** You have been provided with this Contract as evidence of coverage.

17.13 **ERISA.** When this Contract is purchased by the Subscribing Group to provide benefits under a welfare plan governed by ERISA, AvMed will be considered a fiduciary to the extent that it performs any discretionary functions on behalf of the Plan. If a Member has questions about the group's welfare plan, the Member should contact the Subscribing Group.

17.14 **Florida Agency for Health Care Administration (AHCA) Performance Outcome and Financial Data.** The performance outcome and financial data published by AHCA, pursuant to Section 408.05, *Florida Statutes,* or any successor statute, located at the website address, may be accessed through the link provided on AvMed's website at www.avmed.org.

17.15 **Identification Cards.** Cards issued by AvMed to Members pursuant to this Contract are for the purpose of identification only. Possession of an AvMed Identification Card confers no right to Health Care Services or other benefits under this Contract. To be entitled to such services or benefits the holder of the card must be, in fact, a Member on whose behalf all applicable Premiums under this Contract have been paid and accepted by AvMed. Please carry your Identification Card with you and present it before Covered Services are rendered. If your Identification Card is missing, lost, or stolen, contact AvMed's Member Engagement Center at 1-800-376-6651, or visit AvMed's website at www.avmed.org. Member Identification Cards are AvMed's property and, upon request, will be returned to AvMed within 30 days of the termination of your coverage.

17.16 **Membership Application.** Members or applicants for membership will complete and submit to AvMed such applications or other forms or statements as AvMed may reasonably request. If a Member or applicant fails to provide accurate information which AvMed deems material then, upon ten days' written notice, AvMed may deny membership to such individual. Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony, punishable as provided by *Florida Statutes*.

17.17 **Minimum Enrollment Requirement.** This Contract, at the sole option of AvMed, will not be accepted if at the time of the renewal offering to the Subscribing Group the total enrollment does not result in a predetermined minimum enrollment as established by AvMed, pursuant to Florida law. The required minimum group enrollment is included in the Rate Letter (as defined in this Part) furnished to the Subscribing Group.

17.18 **Misrepresentation of Material Fact by Party Applying for Coverage.** Time limit on certain defenses: Fraudulent or intentional misrepresentation of material facts made by the applicant, Subscriber, or Covered Dependents which are discovered by AvMed within two years of the issue date of the Contract may prevent payment of benefits under this Contract and may void this Contract for the individual making the misrepresentation or fraudulent statement. Fraudulent misstatements discovered by AvMed at any time, may result in this Contract being voided or Claims being denied for the individual about whom the fraudulent misstatement is made.

17.19 **Misstatement of Age, Residence or Tobacco Use.** If any written information has been misstated by you, upon 30 days' notice from AvMed, the Premium amount owed under this Contract will be what the Premium would have been had the correct information been provided to AvMed. If such misstatement causes us to accept Premiums for a period during which we would not have accepted Premiums if the correct information had been stated, our only liability will be the return of any unearned Premium. We will not provide any coverage for that period. This right is in addition to any other rights we may have under this Contract and applicable laws.

17.20 **Modification of Provider Network and Participation Status.** The AvMed Elite Plan provider network and the participation status of individual providers available under this Contract are subject to change at any time without prior notice to you or your approval. Additionally, we may at any time terminate or modify the terms of any provider's contract, and may enter into additional provider

contracts, without prior notice to or approval by you. It is your responsibility to determine whether a Health Care Provider is an In-Network Provider at the time the Health Care Service is rendered.

17.21 **Non-Waiver.** Any failure by us at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions described herein, will in no event constitute a waiver of any such terms or conditions. Further, it will not affect our right at any time to enforce or avail ourselves of any such remedies as we may be entitled to under applicable law or this Contract.

17.22 **Notices.** Any notice required or permitted hereunder will be deemed given if hand delivered or if mailed by the United States Postal Service, postage prepaid, and addressed as listed below. Such notice will be deemed effective as of the date delivered or so deposited in the mail.

a. If to us:
   To the address printed on the AvMed Identification Card.

b. If to you:
   To the latest address provided by you according to our records or to the Member's latest address on enrollment forms delivered to us.

c. If to Subscribing Group:
   To the address provided in the Group Master Application.

17.23 **Plan Administration.** AvMed may from time to time adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of this Contract.

17.24 **Premium Tax/Surcharge.** If any government entity imposes a Premium tax or surcharge, then upon 30 days' notice from AvMed, the sums due from the Subscribing Group under the terms of this Contract will be increased by the amount of such Premium tax or surcharge.

17.25 **Promissory Estoppel.** No oral statements, representations, or understanding by any person can change, alter, delete, add, or otherwise modify the express written terms of this Contract.

17.26 **Rate Letter.** The term 'Rate Letter' refers to a compilation of documents which constitute AvMed's formal notice to the Subscribing Group of: (i) the Premium rates applicable to the Subscribing Group, (ii) the conditions under which the rates are valid, (iii) the Premium payment terms and due dates, and (iv) the additional charge which will apply to all late Premium payments. AvMed reserves the right to adjust (re-rate) the Premium rates to account for material changes in group size or in the data supplied by the Subscribing Group to AvMed.

17.27 **Right to Receive Necessary Information.** We have the right to receive, from you and any Health Care Provider rendering services to you, information that is reasonably necessary, as determined by us, to administer the coverage and benefits we provide, subject to all applicable confidentiality requirements listed above. By accepting coverage, you authorize every Health Care Provider who renders services to you, to disclose to us or to entities affiliated with us, upon request, all facts, records, and reports pertaining to your care, treatment, and physical or mental Condition, and to permit us to copy any such records and reports so obtained.

17.28 **Third-Party Beneficiary.** This Contract was issued by AvMed to the Subscriber and was entered into solely and specifically for the benefit of AvMed and the Subscriber. The terms and provisions of the Contract will be binding solely upon, and inure solely to the benefit of, AvMed and the Subscriber, and no other person will have any rights, interest or claims hereunder, or be entitled to sue for a breach hereof as a third-party beneficiary or otherwise. AvMed and the Subscriber hereby specifically express their intent that Health Care Providers that have not entered into contracts with AvMed to render the professional Health Care Services described in this Contract will not be third-party beneficiaries under this Contract.

XVIII. PEDIATRIC DENTAL BENEFITS, LIMITATIONS AND EXCLUSIONS

18.1 **Provision of Pediatric Dental Services and Benefits.** AvMed has arranged for the delivery of pediatric dental services and Benefits for Covered Dependent children from birth through the end of the month in which they turn 19, to be administered by Delta Dental Insurance Company (hereinafter referred to as "Delta Dental").

a. Member Identification Number. Please provide the Enrollee's AvMed Member identification ("ID") number to your Dental Provider whenever you receive pediatric dental services. The Member ID number should be included on all claims submitted for payment. Dental ID cards are not required, but if you wish to have one you may obtain one by visiting Delta's website at www.deltadentalins.com.

b. Customer Service. For more information about the pediatric dental services and Benefits, please visit www.deltadentalins.com, or call Delta Dental's Customer Service Center. A Customer Service representative can answer questions you may have about obtaining dental care, help you locate a Dental Provider, explain Benefits, check the status of a claim and assist you in filing a claim. You can access the automated information line at 800-521-2651 to obtain information about your eligibility, Benefits or claim status or to speak to a dental Customer Service representative for assistance.

18.2 **Dental Plan Definitions.** The following are words that have special or technical meanings under the pediatric dental services and Benefits described in this Part, and made available under this Contract.

a. Accepted Fee means the amount the attending Dental Provider agrees to accept as payment in full for services rendered.

b. Benefits mean the amounts that will be paid for covered pediatric dental services.

c. Claim Form means the standard form used to file a dental claim, request a dental Pre-Treatment Estimate, or request Prior Authorization.

d. Contract Benefit Level is the percentage of the Maximum Contract Allowance paid under the dental plan.

e. Dental Deductible means the dollar amount that an Enrollee must satisfy for certain covered dental services before dental Benefits are paid.

f. Dental Out-of-Pocket Maximum means the maximum amount that a Member will pay during a calendar year for pediatric dental Benefits from a PPO Provider before Delta Dental begins to pay 100% of the PPO Contracted Fee. Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered Dental Services from Dental Premier Providers and Non-Delta Dental Providers even after the Out-of-Pocket Maximum has been met.

g. Dental Provider means a person licensed to practice dentistry when and where services are performed and may be referred to as a "PPO Provider", a "Premier Provider" or a "Non-Delta Dental Provider". A Dental Provider will also include a dental partnership, dental professional corporation or dental clinic.

h. Eligible Pediatric Individual means a Covered Dependent child under age 20 who is eligible for the pediatric dental Benefits described herein.

i. Enrollee means a Covered Dependent child who is an Eligible Pediatric Individual ("Pediatric Enrollee") enrolled to receive Benefits under the dental plan.

j. Enrollee Pays means a Member's financial obligation for services, calculated as the difference between the amount shown as the 'Accepted Fee' and the portion shown as 'Delta Dental Pays' on the claims statement when a claim is processed.

k. Essential Health Benefits ("Pediatric Benefits"). For the purpose of this Part, Essential Health Benefits are certain pediatric oral services that are required to be included under the Affordable Care Act. The services considered to be Essential Health Benefits are determined by state and federal agencies and are available for Eligible Pediatric Individuals.

l. Maximum Contract Allowance is the reimbursement under the Enrollee's Plan against which the Dental Provider payment and the Member's financial obligation are calculated. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:

   i. by a PPO Provider, is the lesser of the Provider's Submitted Fee or the PPO Provider's Contracted Fee; or

   ii. by a Premier Provider, is the lesser of the Provider's Submitted Fee or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area; or

iii. by a Non-Delta Dental Provider, is the lesser of the Provider's Submitted Fee or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area.

m. Non-Delta Dental Provider means a Provider who is not a PPO Provider or a Premier Provider and who is not contractually bound to abide by the dental plan administrative guidelines.

n. PPO Contracted Fee is the fee for each Single Procedure that a Dental PPO Provider has contractually agreed to accept as payment in full for covered services.

o. PPO Provider means a Dental Provider who contracts with the dental plan and agrees to accept the PPO Contracted Fee as payment in full for services provided under the dental plan.

p. Premier® Contracted Fee is the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for covered services.

q. Premier Provider means a Dental Provider who contracts with the dental plan and agrees to accept the Premier Contracted Fee as payment in full for covered services provided under the dental plan.

r. Pre-Treatment Estimate is an estimate of the allowable Benefits under this dental plan for the services proposed, assuming the person is an eligible Enrollee.

s. Procedure Code is the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

t. Single Procedure means a dental procedure that is assigned a separate Procedure Code.

u. Submitted Fee is the amount a Dental Provider bills and enters on a claim for a specific procedure.

18.3 **Overview of Dental Benefits**. The information provided below will give you a better understanding of how the dental plan works and how to make it work best for you.

a. Benefits, Limitations and Exclusions

i. Dental Benefits are payable only for covered services. The dental plan covers several categories of Benefits when a Dental Provider furnishes the services and when they are necessary and within the standards of generally accepted dental practice. Claims will be processed in accordance with the dental plan standard processing policies. Dentists (dental consultants) may be used to review treatment plans, diagnostic materials or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. If you receive dental services from a Dental Provider outside the State of Florida, the Provider will be paid according to the dental network payment provisions for said state according to the terms of the Provider's Contract.

ii. If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable. Even if the Dental Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

b. Enrollee Coinsurance

i. The dental plan will pay a percentage of the Maximum Contract Allowance for covered services, subject to certain Limitations, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Enrollee Coinsurance") and is part of your out-of-pocket cost. You may have to satisfy a Deductible before dental Benefits are paid. You pay the Enrollee Coinsurance even after a Deductible has been met.

ii. The amount of your Enrollee Coinsurance will depend on the type of service and the Dental Provider furnishing the service (see the Section titled **"Selecting Your Dental Provider"**, below). Providers are required to collect Enrollee Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, the dental plan will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.

iii. It is to your advantage to select PPO Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to **"Selecting Your Dental Provider"**, for more information.

c. Pre-Treatment Estimates

i. Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. A Pre-Treatment Estimate will estimate the amount of Benefits payable under the dental plan for the listed services. By asking your Dental Provider for a Pre-Treatment Estimate before the Enrollee receives any prescribed treatment, you will have an estimate up front of what your dental Benefits will pay and the difference you will need to pay. The Benefits will be processed according to the terms of the dental plan when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days or until an earlier occurrence of any one of the following events:

1) the date this Contract terminates;
2) the date the Enrollee's coverage ends; or
3) the date the Dental Provider's agreement with the dental plan ends.

ii. A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount the dental plan will pay if you are covered and meet all the requirements of the plan at the time the planned treatment is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

d. Coordination of Benefits

i. Delta Dental coordinates the dental Benefits under this dental plan with your benefits under any other group or pre-paid plan or insurance plan designed to fully integrate with other plans. If this plan is the "primary" plan, Delta Dental will not reduce Benefits. If this plan is the "secondary" plan, Delta Dental may reduce Benefits so that the total benefits paid or provided by all plans do not exceed 100% of total allowable expense.

ii. How does Delta Dental determine which Plan is the "primary" plan?

1) The plan covering the Enrollee as an employee is primary over a plan covering the Enrollee as a dependent.
2) The plan covering the Enrollee as an employee is primary over a plan covering the insured person as a dependent; except that if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
   a) secondary to the plan covering the insured person as a dependent; and
   b) primary to the plan covering the insured person as other than a dependent (e.g., a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
3) Except as stated in paragraph 4), when this plan and another plan cover the same child as a dependent of different persons, called parents:
   a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
   b) if both parents have the same birthday, the benefits of the plan covering one parent longer are determined before those of the plan covering the other parent for a shorter period.
   c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.

4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody or as a dependent of the custodial parent's spouse (i.e., stepparent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree establishing financial responsibility for the health care expenses with respect to the child, the benefits of a plan covering the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy covering the child as a dependent child.

5) If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph 3).

6) The benefits of a plan covering an insured person as an employee who is neither laid-off nor retired are determined before those of a plan covering that insured person as a laid-off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule 6) is ignored.

7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination.

   a) First, the benefits of a plan covering the insured person as an employee (or as that insured person's dependent).

   b) Second, the benefits under the continuation coverage.

   c) If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule 7) is ignored.

8) If none of the above rules determines the order of benefits, the benefits of the plan covering an employee longer are determined before those of the plan covering that insured person for the shorter term.

9) When determination cannot be made in accordance with the above for Pediatric Benefits, the benefits of a plan that is a medical plan covering dental as a benefit will be primary to a dental only plan.

18.4 **Selecting Your Dental Provider**

a. Free Choice of Provider. You may see any Dental Provider for your covered treatment whether the Provider is a PPO Provider, Premier Provider or a Non-Delta Dental Provider. This plan is a dental PPO plan and the greatest benefits – including out-of-pocket savings – occur when you choose a PPO Provider. To take full advantage of your Benefits, you should verify a dentist's participation status within the dental network before each appointment. Review this section for an explanation of the dental plan payment procedures to understand the method of payments applicable to your Dental Provider selection and how that may impact your out-of-pocket costs.

b. Locating a PPO Provider. You may access information at www.deltadentalins.com. You may also call Delta Dental's Customer Service Center and a representative will provide you with information regarding a Provider's network participation, specialty and office location.

c. Choosing a PPO Provider

   i. The PPO plan potentially allows the greatest reduction in Enrollees' out-of-pocket expenses since this select group of Providers will provide dental Benefits at a charge that has been contractually agreed upon. Payment for covered services performed by a PPO Provider is based on the Maximum Contract Allowance.

   ii. Costs incurred by the Pediatric Enrollee for covered services with a PPO Provider apply towards the Out-of-Pocket Maximum for pediatric dental Benefits.

d. Choosing a Premier Provider

i. A Premier Provider is a participating provider under this dental plan; however, the Premier Provider has not agreed to the features of the PPO plan. The amount charged may be above that accepted by PPO Providers, and Enrollees will be responsible for balance billed amounts. Payment for covered services performed by a Premier Provider is based on the Maximum Contract Allowance, and the Enrollee may be balance billed up to the Premier Provider's Contracted Fee.

ii. Costs incurred by the Pediatric Enrollee with a Premier Provider do not count towards the Out-of-Pocket Maximum for Pediatric Benefits. Enrollee Coinsurance and other cost-sharing, including balance billed amounts, continue to apply when a Premier Provider is used even if the Out-of-Pocket Maximum for Pediatric Enrollees has been met.

e. Choosing a Non-Delta Dental Provider

i. If a Provider is a Non-Delta Dental Provider, the amount charged to Enrollees may be above that accepted by PPO Providers or Premier Providers, and Enrollees will be responsible for balance billed amounts. Payment for covered services performed by a Non-Delta Dental Provider is based on the Maximum Contract Allowance, and the Enrollee may be balance billed up to the Provider's Submitted Fee.

ii. Costs incurred by the Pediatric Enrollee with a Non-Delta Dental Provider do not count towards the Out-of-Pocket Maximum for Pediatric Benefits. Enrollee Coinsurance and other cost-sharing, including balance billed amounts, continue to apply when a Non-Delta Dental Provider is used even if the Out-of-Pocket Maximum for Pediatric Enrollees has been met.

f. Additional Obligations of PPO Providers

i. The PPO Provider or Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly after satisfaction of the Deductible and Enrollee Coinsurance. The Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.

ii. The PPO Provider or Premier Provider will complete the dental Claim Form and submit it to the dental plan for reimbursement.

iii. The PPO Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and PPO Contracted Fees.

g. How to Submit a Claim

i. Claims for Benefits must be filed on a standard Claim Form that is available in most dental offices. PPO and Premier Providers will fill out and submit your claims paperwork for you. Some Non-Delta Dental Providers may also provide this service upon your request. If you receive services from a Non-Delta Dental Provider who does not provide this service, you can submit your own claim directly to the dental plan. Please refer to the section titled "Dental Claim Form" for more information.

ii. Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:

Delta Dental
P.O. Box 1809
Alpharetta, GA 30023-1809
678-297-1972 fax

h. Payment Guidelines

i. PPO or Premier Providers are not paid any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

ii. If you or your Provider files a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Delta Dental Provider, you are still responsible for the full cost. If the payment is denied because your PPO or Premier Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your PPO or Premier Provider that

you were covered under this dental plan at the time you received the service, you may be responsible for the cost of that service.

iii. This dental coverage is arranged by AvMed and administered by Delta Dental. If Delta Dental is unable to pay a dental claim for covered services, AvMed remains responsible for payment of such claim consistent with the terms and conditions of this Contract.

iv. If you have any questions about any dental charges, processing policies and/or how your claim is paid, please contact Delta Dental.

i. Provider Relationships

i. Any PPO, Premier or Non-Delta Dental Provider, including any Provider or employee associated with or employed by them, who provides dental services to an Enrollee does so as an independent contractor and will be solely responsible for dental advice and for performance of dental services, or lack thereof, to the Enrollee.

18.5 **Grievances and Appeals**

a. If you have questions about any pediatric dental services received, please first discuss the matter with your Dental Provider. However, if you continue to have concerns, please call Delta Dental's Customer Service Center. You can also email questions by accessing the "Contact Us" section of the dental plan website at www.deltadentalins.com.

b. Grievances

i. Grievances regarding eligibility, the denial of dental services or claims, the policies, procedures, or the quality of dental services performed by the Dental Provider may be sent in writing to the dental plan or by calling toll-free at 800-521-2651.

ii. When you write, please include the name of the Enrollee, the AvMed Member ID number and your telephone number on all correspondence. You should also include a copy of the Claim Form, claim statement or other relevant information. Your claim statement will have an explanation of the claim review and any grievance process and time limits applicable to such process.

iii. You and your Provider will be notified if Benefits are denied for services submitted on a Claim Form, in whole or in part, based upon lack of medical necessity. Any such denial will be based upon a determination by a Provider who holds a non-restricted license in the same or an appropriate specialty that typically manages the dental condition, procedure or treatment under review. You and your Provider have at least 180 days after receiving a notice of denial to request a review in writing giving reasons why you believe the denial was wrong. Send your grievance to Delta Dental at the address shown below:

Delta Dental
P.O. Box 1809
Alpharetta, GA 30023-1809
678-297-1972 fax

iv. Delta Dental will send you a written acknowledgment within five (5) days upon receipt of your grievance and will review and send you a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the dental Benefits there will be consultation with a dentist who has appropriate training and experience. The review will be conducted by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

c. Appeals

i. If you believe you need further review of your dental claim you may contact your Florida Department of Financial Services. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA), for further review of the claim or

if you have questions about the rights under ERISA. You may also bring a civil action under Section 502(a) of ERISA. The address of the U.S. Department of Labor is:

U.S. Department of Labor,
Employee Benefits Security Administration (EBSA)
200 Constitution Avenue, N.W.
Washington, D.C. 20210.

18.6 **General Provisions**

a. Clinical Examination

i. Before approving a dental claim, Delta may require information and records relating to attendance to or examination, or treatment provided to you, to administer the claim; or may have you be examined by a dental consultant when and as often as may be reasonably required during the pendency of a claim, in or near your community or residence.

b. Written Notice of Dental Claim/Proof of Loss

i. There must be written proof of loss within 12 months after the date of the loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give written proof in the time required provided that the proof is filed as soon as reasonably possible. A notice of claim submitted by you, on your behalf, or on behalf of your beneficiary with information sufficient to identify you will be considered notice of claim.

ii. Send your Notice of Claim/Proof of Loss to Delta Dental at the address shown below:

Delta Dental
P.O. Box 1809
Alpharetta, GA 30023-1809
678-297-1972 fax

c. Claim Form

i. Within 15 days after receiving a notice of a claim, you or your Dental Provider will be provided with a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services, and by the patient (or the parent or guardian if the patient is a minor), and submitted to the address above.

ii. If a Claim Form is not sent to you or your Provider within 15 days after you or your Provider gave notice regarding a claim, the requirements for proof of loss outlined in the section "Written Notice of Claim/Proof of Loss" above will be deemed to have been complied with as long as you give written proof that explains the type and the extent of the loss that you are making a claim for, within the time established for filing proofs of loss. You may also download a Claim Form from the dental plan website at www.deltadentalins.com.

d. Time of Payment

i. Dental claims payable for any loss other than loss that is a periodic payment will be processed no later than 30 days after written proof of loss is received in the form required. You and your Provider will be notified of any additional information needed to process the claim within this 30-day period.

e. To Whom Benefits Are Paid

i. It is not required that the service be provided by a specific dentist. Payment for services provided by a PPO or Premier Provider will be made directly to the dentist. Any other payments will be made to you unless you request in writing when filing a proof of claim that the payment be made directly to the Dental Provider providing the services. All Benefits not paid to the Provider will be payable to you or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to the parent, guardian or other person actually supporting the minor.

f. Non-Discrimination

i. Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ii. Delta Dental:

1) Provides free aids and services to people with disabilities to communicate effectively with us, such as:

a) Qualified sign language interpreters

b) Written information in other formats (large print, audio, accessible electronic formats, other formats)

2) Provides free language services to people whose primary language is not English, such as:

a) Qualified interpreters

b) Information written in other languages

iii. If you need these services, contact Delta Dental's Customer Service Center at 800-471-0236. If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a Customer Service representative, or by mail.

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
Telephone Number: 800-471-0236
Website Address: deltadentalins.com

iv. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

g. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

18.7 **Deductibles, Maximums, Contract Benefit Levels and Enrollee Coinsurances**

Deductibles & Maximums	
Annual Deductible Pediatric Enrollee	 $60 each calendar year
Out-of-Pocket Maximum* Pediatric Enrollee Multiple Pediatric Enrollees	 $400 each calendar year for only one covered Pediatric Enrollee $800 each calendar year for two or more covered Pediatric Enrollees

* Out-of-Pocket Maximum applies only to Essential Health Benefits that are provided by PPO Providers for Pediatric Enrollees. Once the amount paid by Pediatric Enrollees equals the Dental Out-of-Pocket Maximum, no further payment will be required by the Pediatric Enrollees for the remainder of the calendar year for covered services received from PPO Providers. Enrollee Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Premier or Non-Delta Dental Providers even after the Dental Out-of-Pocket Maximum is met.

* If two or more Pediatric Enrollees are covered, the financial obligation for covered services received from PPO Providers is not more than the multiple-Pediatric Enrollees Dental Out-of-Pocket Maximum. However, once a Pediatric Enrollee meets the Dental Out-of-Pocket Maximum for one covered Pediatric Enrollee, that Pediatric Enrollee will have satisfied their Dental Out-of-Pocket Maximum. Other covered Pediatric

Enrollees must continue to pay Enrollee Coinsurance for covered services received from PPO Providers until the total amount paid reaches the Dental Out-of-Pocket Maximum for multiple Pediatric Enrollees.

Contract Benefit Levels & Enrollee Coinsurances		
Dental Service Category	**Delta Dental PPO**[1]	
	Dental Plan[2]	Enrollee[2]
Diagnostic and Preventive Services	100%	0%
Basic Services	50%	50%
Major Services	50%	50%
Medically Necessary Orthodontic Services (requires prior authorization)	50%	50%
Waiting Periods	No Waiting Periods	

[1] Reimbursement is based on PPO Contracted Fees for PPO, Premier and Non-Delta Dental Providers.

[2] The dental plan will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for covered services. Note: payment is the same Contract Benefit Level for covered services performed by a PPO Provider, Premier Provider and a Non-Delta Dental Provider. However, the amount charged to Enrollees for covered services performed by a Premier Provider or Non-Delta Dental Provider may be above that accepted by PPO Providers, and Enrollees will be responsible for balance billed amounts.

18.8 **Description of Dental Services**

a. The dental plan will pay or otherwise discharge the Contract Benefit Level shown in the previous Section for Essential Health Benefits when provided by a Dental Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthodontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health. Benefits for medically necessary orthodontics will be provided in periodic payments based on continued enrollment.

b. Diagnostic and Preventive Services

1.	Diagnostic:	procedures to aid the Provider in determining required dental treatment.
2.	Preventive:	cleaning (including scaling in presence of generalized moderate or severe gingival inflammation – full mouth (periodontal maintenance is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
3.	Sealants:	topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
4.	Specialist Consultations:	opinion or advice requested by a general dentist.

c. Basic Services

1.	General Anesthesia or IV Sedation:	when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
2.	Periodontal Cleanings:	periodontal maintenance.
3.	Palliative:	emergency treatment to relieve pain.
4.	Restorative:	amalgam and resin-based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions

		(visible destruction of hard tooth structure resulting from the process of decay).

d. Major Services

1.	Crowns and Inlays/Onlays:	treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
2.	Prosthodontics:	procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
3.	Oral Surgery:	extractions and certain other surgical procedures (including pre-and post-operative care).
4.	Endodontics:	treatment of diseases and injuries of the tooth pulp.
5.	Periodontics:	treatment of gums and bones supporting teeth.
6.	Denture Repairs:	repair to partial or complete dentures, including rebase procedures and relining.
7.	Night Guards/ Occlusal Guards:	intraoral removable appliances provided for treatment of harmful oral habits.

e. Note on additional Benefits during pregnancy. When an Enrollee is pregnant, the dental plan will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each calendar year while the Enrollee is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Enrollee or the Enrollee's Provider when the claim is submitted.

18.9 **Limitations**

a. Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.

b. If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means the dental plan will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

c. Claims shall be processed in accordance with the dental plan's standard processing policies. The processing policies may be revised from time to time; therefore, the dental plan shall use the processing policies that are in effect at the time the claim is processed. Dentists (dental consultants) may be used to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.

d. If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the dental Benefit payable. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

e. Exam and cleaning limitations

i. The dental plan will pay for oral examinations (except after-hours exams and exams for observation) and routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) no more than once every six (6) months. Periodontal maintenance are limited to four (4) times in a 12-month period. Up to four (4) periodontal maintenance procedures and up to two (2)

routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (or any combination thereof) not to exceed four (4) procedures in a 12-month period. See note on additional Benefits during pregnancy.

ii. A full mouth debridement is allowed once in a lifetime, when the Enrollee has no history of prophylaxis, scaling and root planing, periodontal surgery, or periodontal maintenance procedures within three years, and counts toward the cleaning frequency in the year provided.

iii. Note that periodontal maintenance, Procedure Codes that include periodonotal maintenance, and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in presence of generalized moderate or severe gingival inflammation are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

iv. Caries risk assessments are allowed once in 12 months.

v. Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.

f. Application of caries arresting medicament is limited to twice per tooth per calendar year.

g. X-ray limitations:

i. The dental plan will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.

ii. When a panoramic film is submitted with supplemental films, the dental plan will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.

iii. If a panoramic film is taken in conjunction with an intraoral complete series, the dental plan considers the panoramic film to be included in the complete series.

iv. A complete intraoral series and panoramic film are each limited to once every 60 months.

v. Bitewing x-rays are limited to once every six (6) months. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

vi. Image capture procedures are not separately allowable services.

h. The fee for pulp vitality tests is included in the fee for any definitive treatment performed on the same date.

i. Topical application of fluoride solutions is limited to twice within a 12-month period.

j. A distal shoe space maintainer - fixed - unilateral is limited to children 8 and younger and is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe. The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

k. Sealants are limited as follows:

i. once in 36 months to permanent molars if they are without caries (decay) or restorations on the occlusal surface.

ii. repair or replacement of a Sealant on any tooth within 24 months of its application is included in the fee for the original placement.

l. Preventive resin restorations in a moderate to high risk caries risk patient - permanent tooth are limited to once per tooth in 36 months.

m. Specialist Consultations count toward the oral exam frequency. Screenings of patients or assessments of patients reported individually when covered, are limited to only one in a 12-month period and included if reported, with any other examination on the same date of service and Provider office.

n. The dental plan will not cover replacement of an amalgam or resin-based composite restorations (fillings) within 24 months of treatment if the service is provided by the same

Provider/Provider office. Prefabricated crowns are limited to once per Enrollee per tooth in any 60-month period. Replacement restorations within 24 months are included in the fee for the original restoration.

o. Protective restorations (sedative fillings) are allowed when definitive treatment is not performed on the same date of service. The fee for protective restorations are included in the fee for any definitive treatment performed on the same date.

p. Prefabricated stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth through age 14. Replacement restorations within 24 months are included in the fee for the original restoration.

q. Therapeutic pulpotomy is limited to baby (deciduous) teeth only; an allowance for an emergency palliative treatment is made when performed on permanent teeth.

r. Pulpal therapy (resorbable filling) is limited to once in a lifetime and to primary incisor teeth for Enrollees up to age 6 and for primary molars and cuspids up to age 11. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.

s. Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation.

t. Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

u. Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.

v. Palliative treatment is covered per visit, not per tooth, and the fee for palliative treatment provided in conjunction with any procedures other than x-rays or select Diagnostic procedures is considered included in the fee for the definitive treatment.

w. Periodontal limitations:

    i. Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period. In the absence of supporting documentation, no more than two quadrants of scaling and root planing will be benefited on the same date of service. See note on additional Benefits during pregnancy.

    ii. Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing performed within 36-months by the same dentist/dental office.

    iii. Periodontal services, including graft procedures are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.

    iv. Bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.

    v. Periodontal surgery is subject to a 30-day wait following periodontal scaling and root planing in the same quadrant.

    vi. Cleanings (regular and periodontal) and full mouth debridement are subject to a 30-day wait following periodontal scaling and root planing if performed by the same Provider office.

    vii. When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a basic benefit and are limited to once in a 24-month period.

x. Collection and application of autologous blood concentrate product are limited to once every 36 months.

y. Crowns and Inlays/Onlays are covered not more often than once in any 60-month period except when the dental plan determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss

or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.

z. Core buildup, including any pins, are covered not more than once in any 60-month period.

aa. Prefabricated post and core, in addition to crown is covered once per tooth every 60 month period.

bb. Resin infiltration of incipient smooth surface lesions is covered once in any 36-month period.

cc. When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

dd. Prosthodontic appliances, implants and/or implant supported prosthetics (except for implant/abutment supported removable dentures) that were provided under any dental program will be replaced only after 60 months have passed, except when it is determined that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under the dental program will be made if it is determined to be unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. The dental plan's payment for implant removal is limited to one (1) for each implant within a 60-month period whether provided under the dental plan or any other dental care plan

ee. Debridement and/or osseous contouring of a peri-implant defect, or defects surrounding a single implant, and includes surface cleaning of the exposed implant surface, including flap entry and closure is allowed once every 60-month period.

ff. An implant is a covered procedure of the plan only if determined to be a dental necessity. If an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.

gg. When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

hh. Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement.

ii. The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under the dental plan.

jj. The dental plan limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six (6) months after placement.

    i. Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.

    ii. Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, relining are limited to one (1) per arch in a 36-month period. Immediate dentures, and immediate removable partial dentures include adjustments for three (3) months following installation. After the initial three (3) months of an adjustment or reline, relining is limited to one (1) per arch in a 36 month period.

    iii. Tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.

kk. Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint

dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period. The repair or replacement of any appliances for Night Guard/Occlusal Guard are not covered. Adjustment of an occlusal guard is allowed once in 12-months following six months from initial placement.

ll. Limitations on Orthodontic Services

i. Services are limited to medically necessary orthodontics when provided by a Provider. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained.

mm. Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.

nn. The automatic qualifying conditions are:

i. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,

ii. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,

iii. A crossbite of individual anterior teeth causing destruction of soft tissue,

iv. Severe traumatic deviation.

oo. The following documentation must be submitted with the request for prior authorization of services by the Provider:

i. ADA 2006 or newer claim form with service code(s) requested;

ii. Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;

iii. Cephalometric radiographic image or panoramic radiographic image;

iv. HLD score sheet completed and signed by the Orthodontist; and

v. Treatment plan.

pp. The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted.

qq. Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.

rr. Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Enrollees under the age of 19 and shall be prior authorized.

ss. Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

tt. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

uu. When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, the dental plan will make an allowance for the cost of a standard orthodontic treatment. The Enrollee is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.

vv. Repair and replacement of an orthodontic appliance inserted under this dental plan that has been damaged, lost, stolen, or misplaced is not a covered service.

ww. Orthodontic, including oral evaluations and all treatment must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. The dentist of record

must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. Self-administered orthodontics are not covered.

xx. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

yy. The fees for synchronous/asynchronous teledentistry services are considered inclusive in overall patient management and are not a separately payable service.

18.10 **Exclusions. Dental Benefits are not payable for:**

a. services that are not Essential Health Benefits.

b. treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.

c. cosmetic surgery or procedures for purely cosmetic reasons.

d. maxillofacial prosthetics.

e. provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.

f. services for congenital (hereditary) or developmental (following birth) malformations, including cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.

g. treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments.

h. any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.

i. prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.

j. charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.

k. extraoral grafts (grafting of tissues from outside the mouth to oral tissues).

l. laboratory processed crowns for teeth that are not developmentally mature.

m. endodontic endosseous implants.

n. indirectly fabricated resin-based Inlays/Onlays.

o. charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.

p. treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.

q. charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.

r. dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of

providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.

s. procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.

t. any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

u. Deductibles and/or any service not covered under the dental plan.

v. services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

w. the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Contract or was covered under any dental care plan. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

x. services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.

y. services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a prior authorization is obtained.

z. missed and/or cancelled appointments.

aa. actions taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.

bb. the fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

cc. dental case management motivational interviewing and patient education to improve oral health literacy.

dd. non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.

ee. extra-oral – 2D projection radiographic image and extra-oral posterior dental radiographic image.

ff. diabetes testing.

gg. corticotomy (specialized oral surgery procedure associated with orthodontics).

hh. antigen or antibody testing.

ii. counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.