AvMed Entrust™ Plan
For Individuals and Families

Medical and Hospital Service Contract

This Contract Contains Deductible Provisions

For Member Engagement Call:
1-800-477-8768

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President & COO

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AVMED ENTRUST™ PLAN FOR INDIVIDUALS AND FAMILIES
MEDICAL AND HOSPITAL SERVICE CONTRACT

IN CONSIDERATION of the payment of pre-paid monthly Premiums as described in this Contract, AvMed, Inc., a private Florida not-for-profit corporation, state licensed as a health maintenance organization under Chapter 641, *Florida Statutes* (AvMed), and the Contractholder as named on the Application for Coverage, agree as follows:

I. INTRODUCTION

1.1 **Reliance on Applicant Information.** You have been provided with this Contract as evidence of coverage. Issuance of this Contract is based on your answers to question on your Application or HealthCare.gov account. If for any reason your answers are incorrect or incomplete you may notify us, or the Marketplace if applicable, within ten calendar days. Failure to provide accurate and complete information could cause your Claim to be denied or this Contract to be cancelled or rescinded.

1.2 **Ten Day Review Period.** Please read your Contract carefully. If you are not satisfied for any reason, you may return the Contract and AvMed Identification card to us within ten calendar days. The Contract will be cancelled from its effective date, and any unused Premium will be refunded.

1.3 **Contract Enforcement.** This Contract is not enforceable until an Application has been received and accepted by AvMed, or the Marketplace if applicable, the individuals named on the Application are determined to be eligible for coverage under this Contract, and we have received the Contractholder's first Premium payment. The amount of the Contractholder's initial monthly Premium is indicated on the front cover of this Contract.

1.4 **Provision of Health Care Services and Benefits.** During the term of this Contract, we agree to arrange for the provision of Covered Benefits or Covered Services which are Medically Necessary for the diagnosis and treatment of Members, subject to all applicable terms, conditions, Limitations and Exclusions set forth herein. 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.

1.5 **Interpretation.** In order to provide the advantages of Hospital and medical facilities and of the Participating 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 herein.

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

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

b. Many of the provisions of this Contract are interrelated. Therefore, reading just one or two provisions may give you a misleading impression. Many words used in this Contract have special meanings (see Part II. DEFINITIONS).

c. The headings of Parts and Sections contained in this Contract are for reference purposes only and will not affect in any way the meaning or interpretation of particular provisions.

1.7 **References in this Contract**

a. References to "you" or "your" throughout refer to you as the Contractholder 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 Contractholder or solely to your Covered Dependents will be noted as such.

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

c. Whenever used, the singular will include the plural and the plural the singular, and the use of any gender will include all genders.

d. References to the "Plan" refer to this AvMed Entrust™ Plan Individual and Family Medical and Hospital Service Contract.

e. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If a word or phrase has a defined meaning, it will either be in Part II. DEFINITIONS or defined within the particular section where it is used.

1.8 **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 the 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.

1.9 **Guaranteed Contract Renewal.** This Contract is guaranteed renewable, subject to AvMed's right to discontinue or terminate coverage as described herein. **Renewals occur on the first day of January each year.** Upon renewal, the term of coverage will be no less than 12-months, unless otherwise requested by the Contractholder in writing. Coverage will stay in effect as long as you and your Covered Dependents meet the applicable eligibility requirements, live in the Service Area, and pay your Premiums on time. Members are subject to all terms, conditions, Limitations, and Exclusions in this Contract and to all of the rules and regulations of the Plan. By paying Premiums or having Premiums paid on your behalf, you accept the provisions of this Contract.

1.10 **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 will have the meaning indicated. You can visit www.healthcare.gov/glossary to review 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 **Advance Premium Tax Credit (APTC)** means a tax credit that can help an individual afford coverage purchased through the Marketplace. Unlike tax credits that are claimed when filing taxes, these tax credits can be used right away to lower monthly Premiums. If you qualify for APTC payments, you may choose how much to apply to your Premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you are due, you will get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

2.3 **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.

2.4 **Allowed Amount** means the maximum amount established by AvMed upon which payment will be based for Covered Services rendered by In-Network Providers. The Allowed Amount may be changed at any time without notice to you or your consent.

2.5 **Ambulatory Surgery Center** means a facility licensed pursuant to Chapter 395, *Florida Statutes*, the primary purpose of which is to provide surgical care to a patient admitted to, and discharged from, such facility within 24 hours.

2.6 **Application for Coverage** and **Change Form** mean the form(s) provided by or acceptable to AvMed, including Applications received through the Health Insurance Marketplace, which an individual must complete and submit to AvMed (i) when applying for Membership as a Contractholder; (ii) on behalf of a Primary Applicant for child-only coverage; or (iii) when adding eligible dependents.

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

2.8 **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 Entrust Plan Members. These are also referred to as "In-Network Providers."

2.9 **Birthing Center** means a facility licensed pursuant to Chapter 383, *Florida Statutes*, 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.

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

2.11 **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 Contractholder and Covered Dependents. Third-party Copayment assistance (sometimes also referred to as a "copay card" or "copay coupon") provided by a drug manufacturer toward your cost-sharing for Covered Services including Specialty Medications, does not apply toward satisfaction of the Deductible.

2.12 **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 for Covered Services during the same calendar year. This limit never includes Premiums, Prescription Drug Brand Additional Charges, third-party Copayment assistance (sometimes also referred to as a "copay card" or "copay coupon") provided by a drug manufacturer toward your cost-sharing for Covered Services including Specialty Medications, or charges for health care that AvMed does not cover.

2.13 **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 of time 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.

2.14 **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.

2.15 **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 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.

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

2.17 **Contract** means this AvMed Entrust™ Plan for Individuals and Families Medical and Hospital Service Contract, which may at times be referred to as **"Individual Contract"** and all Applications, schedules, amendments, and any other document approved by the Florida Office of Insurance Regulation for incorporation into this Contract.

2.18 **Contractholder** means a Primary Applicant who meets the applicable eligibility requirements described in this Contract, and is enrolled and actually covered under this Contract other than as a Covered Dependent, or as a Member in the case of child-only coverage, and for whom the Premium prepayment required by Part VI. PREMIUMS, COPAYMENTS, COINSURANCE, DEDUCTIBLES, AND OTHER EXPENSES has been received by AvMed.

2.19 **Contract Year:** the 12 months starting on January 1st and each subsequent 12-month period thereafter. Contract Year can be less than 12 months if a Member has an effective date mid-year due to a Qualifying Event, or other exceptional circumstance as determined by the Exchange.

2.20 **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 for the Covered Service, or a portion of the Maximum Medicare Allowable or Average Wholesale Price, for the Covered Service.

2.21 **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 in Coverage Criteria for covered products and services.

2.22 **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.

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

2.24 **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.

2.25 **Dental Care** means:

a. dental x-rays, examinations and treatment of the teeth or any services, supplies or charges directly 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, that are customarily provided by dentists (including orthodontics, reconstructive jaw surgery, casts, splints and services for dental malocclusion).

b. Except as described in Part IX COVERED MEDICAL SERVICES, Dental Care is covered only for children through the end of the month in which they turn 19. Covered pediatric dental benefits are available from Delta Dental Contract Dentists, Contract Specialists and Contract Orthodontists as described in Part XVIII. PEDIATRIC DENTAL BENEFITS, LIMITATIONS AND EXCLUSIONS.

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

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

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

2.28 **Emergency Medical Condition** means:

a. A Condition manifesting itself by acute symptoms of sufficient severity such 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 fetus;
   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 fetus; 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.

2.29 **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.

a. In-area emergency does not include elective or routine care, care of minor illnesses or care that can reasonably be sought and obtained from the Member's in-network Physician. 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.

b. Out-of-area emergency does not include care for Conditions for which a Member could reasonably have foreseen the need of such care before leaving the Service Area or care that could safely be delayed until prompt return to the Service Area. 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.

2.30 **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).

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

2.32 **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.

2.33 **Explanation of Benefits (EOB)** means the statement AvMed sends to you to explain what items or services we paid for on your behalf, how much we paid, and your cost-sharing responsibility pursuant to the terms of the Plan. The EOB is not a bill. It simply explains how your benefits were applied to that particular Claim.

2.34 **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.

2.35 **Habilitation Services** are services that help a person keep, learn or improve skills and functioning for daily living. Such services may be provided in order 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.

2.36 **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.

2.37 **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 injury or illness.

2.38 **Health Insurance Marketplace** or **Marketplace** is a program established as a result of the Affordable Care Act (ACA) that helps Individuals and small businesses shop for and purchase Qualified Health Plans (QHPs). Purchasing a QHP through the Marketplace may allow an individual to qualify for financial assistance in the form of premium tax credits or cost-sharing reductions.

2.39 **Health Professional** 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.

2.40 **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.

2.41 **Hospice** means a public agency or private organization licensed pursuant to Chapter 400, *Florida Statutes,* 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.

2.42 **Hospital** means a facility licensed pursuant to Chapter 395, *Florida Statutes,* 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.

2.43 **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 or not they are obtained at a Hospital-owned or Hospital-affiliated facility. Also see **Independent Facility** below.

2.44 **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 a particular individual is eligible for, or covered under, this Contract.

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

2.46 **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.

2.47 **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 Entrust Plan Members. For a listing of In-Network Providers, please refer to your AvMed Entrust Plan Provider Directory or visit our online directory at www.avmed.org.

2.48 **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.

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

2.50 **Material Misrepresentation** means the omission, concealment of facts or incorrect statements made on any application or enrollment forms by an applicant, Contractholder 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.

2.51 **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, except for Emergency Medical Services and Care as defined herein. The Maximum Allowable Payment may be changed at any time by AvMed without notice to you or your consent.

2.52 **Medical Office** means any outpatient facility or Health Professional's office within the Entrust Plan Service Area utilized by an in-network Health Professional.

2.53 **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.

2.54 **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.

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

2.56 **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.

2.57 **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.

2.58 **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.

2.59 **Open Enrollment Period ("OEP")** or **Open Enrollment ("OE")** means the period of time, as determined by the Marketplace or the Health Plan, during which individuals who are eligible to enroll can enroll in a plan offered by the Health Plan or in a plan offered through the Marketplace. Each year, individuals have a chance to make changes to their Coverage in the Marketplace during Open Enrollment. Individuals may also qualify for SEPs outside of Open Enrollment if they experience certain events.

2.60 **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.

2.61 **Other Health Care Facility(ies)** 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.

2.62 **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.

2.63 **Outpatient Rehabilitation Facility** means an entity that renders, through Health Professionals licensed pursuant to Florida 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*.

2.64 **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.

2.65 **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.

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

2.67 **Physician** means any Health Professional licensed under Chapter 458 (Physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes*.

2.68 **Premium** means the amount a Contractholder must pay to AvMed monthly 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.

2.69 **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.

2.70 **Primary Applicant** means an eligible individual who submits a completed Application for coverage under this Contract on behalf of himself and his eligible dependents, or on behalf of an eligible Primary Applicant for child-only coverage under this Contract.

2.71 **Primary Care Physician (PCP)** means any Entrust 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.

2.72 **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.

2.73 **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.

2.74 **Qualified Health Plan (QHP)** means a health benefit plan approved by the Federal Government to be available for sale through the Marketplace. QHPs that are approved for sale through the Marketplace may also be available directly from private health insurers. Individuals purchasing QHPs through the Marketplace may qualify to receive financial assistance toward Premiums or cost-sharing, which is only available for QHPs purchased through the Marketplace.

2.75 **Qualified Individual:** an individual determined by the Marketplace to be eligible to enroll through the Marketplace.

2.76 **Qualifying Event** means an event that results in a loss of health coverage, a change in household, a change in residence or other life circumstance, established by federal and state law, which triggers a Special Enrollment Period (SEP) for an individual or family to purchase health coverage outside of the regular annual Open Enrollment Period. Sometimes known as a "life event" or "life change".

2.77 **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.

2.78 **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.

2.79 **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.

2.80 **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 from In-Network Providers to Members of the AvMed Entrust Plan.

2.81 **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.

2.82 **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.

2.83 **Skilled Nursing Facility** means an institution or part thereof that is licensed as a Skilled Nursing Facility by the State of Florida, 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.

2.84 **Sound Natural Teeth (Tooth)** means teeth that are whole or properly restored (restoration with amalgams, resin or composite only); are without impairment, periodontal, or other Conditions; and are not in need of services provided for any reason other than an Accidental Dental Injury. 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.

2.85 **Specialty Physician** means any in-network Physician licensed under Chapter 458 (Physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes,* other than the Member's Primary Care Physician.

2.86 **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.

2.87 **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.

2.88 **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.

2.89 **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.

2.90 **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 serious injury or disability if left untreated.

2.91 **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.

2.92 **Ventilator Dependent Care Unit** means any facility, other than an acute care Hospital setting, that 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.

2.93 **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 individual and the dependents of an individual who meet and continue to meet the eligibility requirements described in this Contract, or as set forth by the Health Insurance Marketplace, will be entitled to enroll in coverage under this Contract. These eligibility requirements are binding upon you and your eligible dependents. We may require acceptable documentation that an individual meets and continues to meet the eligibility requirements (e.g. proof of residency, copies of a court order naming the Contractholder as legal guardian, or appropriate adoption documentation, as described in Part IV. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE).

3.1 **Contractholder Eligibility.**

a. To be eligible to apply for coverage as a Contractholder you must be determined by AvMed, or the Marketplace if applicable, to meet the following requirements:
   i. Be a U.S. Citizen or national (or be lawfully present);
   ii. Maintain continuous primary residence in the Service Area;
   iii. Not be enrolled in Medicare as of the effective date of coverage;
   iv. Not be eligible for Medicaid as of the effective date of coverage;
   v. Not be currently incarcerated;
   vi. Submit a completed and signed Application for coverage including all requested information, or apply through the Marketplace; and
   vii. Pay the required Premiums.

b. Catastrophic Coverage. In addition to the eligibility requirements listed above, individuals applying for a Catastrophic plan must also meet one of the following requirements. Catastrophic plans must be purchased through the Marketplace to determine eligibility.
   i. be under the age of 30; or
   ii. qualify for and have received a hardship exemption from the Marketplace.

c. Child-Only Coverage. An individual who meets the eligibility requirements listed above, who is not eligible for CHIP, and who has not reached age 21 as of the coverage effective date, is eligible for a child-only plan. If coverage is purchased through the Marketplace, an Advance Premium Tax Credit (APTC) may be available to the parent or legal guardian who purchases coverage on behalf of a qualifying dependent child. In determining the parent's/legal guardian's premium tax credit eligibility, a qualifying dependent child is defined as:
   i. A child of the taxpayer or descendent of such child. The brother, sister, stepbrother, or stepsister of the taxpayer or a descendent of any such relative;
   ii. Has the same principal place of residence as the taxpayer for more than half of the year; Has not reached the age of 19 by the end of the calendar year, is a student who has not reached the age of 24 by the end of the calendar year, or is permanently disabled; and
   iii. has not provided over one-half of his or her own support for the calendar year; and has not filed a joint return with his or her spouse.
   iv. As specified by the Affordable Care Act (ACA), the parent/legal guardian who claims the child on their tax return must provide that child with coverage.

3.2 **Dependent Eligibility.** To be eligible to enroll as a Covered Dependent, an individual must be determined by AvMed, or the Marketplace if applicable, to meet the following requirements:

a. Maintain continuous primary residence in the Service Area;
b. Not be entitled to Medicare or eligible for Medicaid/CHIP as of the effective date of coverage;
c. Be named on the initial Application for this Contract, or properly enrolled thereafter;
d. Be the Contractholder's spouse under a legally valid existing marriage; or
e. Be the natural, adopted, step child, or foster child of the Contractholder or the Contractholder's Covered Dependent spouse, until the end of the month in which the child reaches age 26;

f. Be a child for whom the Contractholder or the Contractholder's Covered Dependent spouse has been appointed legal guardian or legal custodian pursuant to a valid court order, until the end of the month in which the child reaches age 26;

g. Be a child for whom the Contractholder or the Contractholder's Covered Dependent spouse is obligated by a Qualified Medical Child Support Order (QMCSO) to provide medical coverage, until the end of the month in which the child reaches age 26. An order may not require a plan to provide any type or form of benefit or option not otherwise provided under the plan, except to the extent required by law (you may obtain copies of the Plan's procedures governing QMCSOs and a sample QMCSO without charge by contacting AvMed);

h. Be the newborn child of a Covered Dependent child of the Contractholder (such coverage terminates 18 months after the birth of the newborn child); and

i. Pay the required Premiums.

3.3 **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 individual health benefits plan, group, blanket or franchise health insurance policy, 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 Contractholder 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.

3.4 **Eligibility Requirements Control.** The eligibility requirements described in this Contract and on the Application for coverage will at all times control and no other coverage will be permitted unless the Health Insurance Marketplace notifies AvMed of the change and AvMed has agreed, in writing

to the change in advance or, if applicable, in accordance with AvMed's agreement with the Health Insurance Marketplace.

3.5 **Enrollment Restriction.** No individual is eligible to enroll for coverage under this Contract whose AvMed coverage was previously terminated for non-payment of Premium, except with AvMed's written approval. If your coverage was previously terminated for non-payment of Premiums you are not eligible to enroll for coverage under this Contract without paying to us all past due Premiums under the Contract applicable in the previous 12 months, and any other amounts owed to us, including the first month Premium prepayment due under this Contract. No individual whose AvMed coverage was previously terminated for cause is eligible to enroll for coverage under this Contract.

IV. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

With respect to eligible individuals properly enrolled, coverage first becomes effective at 12:00 a.m. (midnight) on the date shown on the cover page of this Contract. 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 for coverage will not be covered under this Contract. AvMed has no obligation whatsoever to any individual who is not properly enrolled.

4.1 **General Rules for Enrollment**

a. All factual representations made by you, in connection with enrollment for coverage in the Plan and the issuance of this Contract, must be accurate and complete. Any false or intentionally misleading information provided during the enrollment process or at any other time may result, in addition to any other legal rights we may have, in disqualification for, termination of, or rescission of coverage.

b. Fraud or intentional misrepresentation of material fact, omissions, concealment of facts, and incorrect statements made by you, or your Covered Dependents, which are discovered by us or the Marketplace, may prevent payment of benefits under this Contract, may void this Contract, and may cause Claims to be denied for the individual making, or the subject of, the misrepresentation, omission, concealment of facts or incorrect statement. Fraudulent misstatements discovered by us or the Marketplace, at any time, may result in this Contract being voided or Claims being denied for the individual making or responsible for the fraudulent misstatement. 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*.

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

d. If, in applying for this Contract or in enrolling yourself or your dependents, you make a fraudulent statement or misrepresentation pertaining to information such as your geographical area, gender, age, or the gender and/or age of your dependents, our sole liability will be the return of any unearned Premium, less benefit payments. However, at our discretion, we may elect to cancel the Contract with forty-five days' prior written notice; or continue this Contract if, upon 30 days' written notice from us, you make payment to us for the full amount of the Premium which would have been in effect had you stated the true facts.

e. Eligible individuals may enroll in the Plan with us, or through the Marketplace at HealthCare.gov. The Marketplace follows enrollment rules specified by the Federal Government and the State of Florida. These enrollment rules may or may not apply if you enroll in the Plan directly with us. If you enroll in the Plan through the Marketplace, you may be eligible for tax credits to help pay for your cost of coverage. The following sections discuss the rules and benefits of enrollment through the Marketplace.

4.2 **Applying for Coverage.** This Section gives an overview of how to apply for coverage under this Contract, through the Marketplace, or directly with AvMed. Rules for enrolling during specific enrollment periods, for changing coverage, and for adding eligible dependents are described in Sections 4.3 Enrollment Periods and 4.4 Qualifying Events, SEPs and Effective Dates of Coverage.

a. To apply for coverage under this Contract through the Marketplace, you must:
   i. Create a Marketplace account on HealthCare.gov;
   ii. Fill out and submit an online application or download and complete a paper application. You can also apply by phone or in-person with an assister;
   iii. You will receive a notice in the mail or in an email that tells you what coverage you are eligible for. Review and save this notice.
   iv. If you are eligible, shop for an AvMed Marketplace plan and enroll on behalf of yourself and/or your eligible dependents you want to cover; and
   v. Send your first Premium payment to us.

b. To apply for coverage under this Contract directly through AvMed, outside of the Marketplace, you must:
   i. Complete an online application, or download and complete a paper application, and submit it to us on behalf of yourself and/or your eligible dependents you want to cover;
   ii. Provide information needed to determine eligibility, as requested; and
   iii. Pay the required Premium.

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

4.3 **Enrollment Periods**

a. Annual Open Enrollment Period (OEP). The OEP is the period of time each year, determined by the Marketplace or AvMed, when you can apply for individual coverage or change your coverage. If you apply for and are enrolled in coverage during the open enrollment period, the effective date of your new coverage will be January 1st. If you don't apply for or change your coverage during the OEP you must wait until the next OEP, or an SEP if applicable.

b. Special Enrollment Periods (SEP). To apply for coverage outside of the annual OEP, you must qualify for an SEP. An SEP is a period of time up to 60 days immediately following the date of a Qualifying Event when you and your eligible dependents may apply for individual coverage or change your coverage. You may be required to provide proof of the qualifying event, such as: a notification of the termination of other coverage, marriage certificate, appropriate adoption documentation, or court order requiring coverage. The effective date of your new coverage depends on the type of qualifying event that occurred. If you qualify for an SEP and do not apply for or make changes to your coverage during the SEP, you must wait until the next OEP, or a later SEP if applicable.

4.4 **Qualifying Events, SEPs and Effective Dates of Coverage.**

a. Loss of Other Coverage. A loss of coverage due to an individual's failure to pay Premiums on a timely basis (including COBRA Premiums), or termination of coverage for cause (fraud or intentional misrepresentation of material fact), will not trigger a special enrollment period.
   i. If you lose coverage due to any of the following triggering events, you and your eligible dependents can apply for coverage within *60 days after* the date of the triggering event. If you apply and are enrolled by the 15th of the month, your new coverage will be effective on the first day of the following month. If you apply and are enrolled between the 16th and the last day of the month, your new coverage will be effective on the first day of the second following month.
      1) termination of employment or reduction in hours of employment
      2) termination of employer Premium contributions;

3) change in dependent status due to divorce, annulment or the death of a covered employee whose employment afforded dependent coverage;

4) relocation out of an HMO service area (you must provide proof of having minimum essential coverage, as defined by the Affordable Care Act (ACA), for one or more days during the 60 days immediately preceding the date of the move);

5) a bankruptcy filing by an employer from which a covered employee has retired at the time of the bankruptcy filing.

ii. If you lose coverage due to any of the following triggering events, you and your eligible dependents can apply for coverage within *60 days before or 60 days after* the date of the triggering event. If you apply for coverage and are enrolled before or on the date of the triggering event, coverage will be effective on the first day of the month following the event. If you apply for coverage and are enrolled after the date of the triggering event, coverage will be effective on the first day of the month following receipt of the required information.

1) loss of minimum essential coverage (as defined by the ACA);

2) the last day of an individual's enrollment in a non-calendar year group health plan or individual health insurance coverage, even if the individual has the option to renew;

3) loss of pregnancy-related Medicaid coverage;

4) loss of medically needy Medicaid coverage (no more than once a year).

b. Gaining a Dependent.

i. If you gain a new dependent due to any of the following triggering events you can apply for coverage for yourself and your eligible dependent, or you can apply to change your coverage and add your eligible dependent, within *60 days after* the date of the triggering event. Adding an eligible dependent may increase the cost of your Premium. You must pay the additional Premium due for coverage to be provided to the eligible dependent.

1) *Marriage.* The effective date of coverage for an eligible dependent spouse properly enrolled will be the first date of the month following enrollment.

2) *Birth.* The effective date of coverage for a natural newborn child properly enrolled will be the moment of birth. The effective date of coverage for an adopted newborn child properly enrolled will be the moment of birth provided a written agreement to adopt such child was entered into by the Contractholder prior to the child's birth.

a) If you enroll an eligible newborn child within 30 days after the date of birth, no additional Premium will be charged for the newborn child's coverage for the 30-day period immediately following the newborn's birth.

b) If you enroll an eligible newborn child within 31 to 60 days after the date of birth, we will charge the applicable Premium for the newborn child's coverage from the date of birth.

3) *Adopted children other than newborns.* The effective date of coverage for a child placed in your home for adoption or adopted, and properly enrolled, will be the date of placement in your home for adoption, or adoption, whichever is earlier.

4) *For all children covered as adopted children,* coverage will not be required if the child is not ultimately placed in the Contractholder's home in compliance with Chapter 63, Florida Statutes. If the final decree of adoption is not issued, coverage will not be continued for the proposed adopted child. Proof of final adoption must be submitted to us. It is your responsibility to notify us if the adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child on the first billing date following receipt of the written notice.

5) *Foster children.* The effective date of coverage for a child placed in your home for foster care, and properly enrolled, will be the date of placement in your home.

c. Child support order or other court order (except for a court order to cover a former spouse). If a court has ordered you to provide coverage for a minor child who is an eligible dependent, you must enroll the child *within 60 days after* the date of the order. The effective date of coverage for the eligible dependent will be the date of the order. You must pay the additional Premium for coverage to be provided for the eligible dependent.

d. Changes in Marketplace Enrollment. If you or your eligible dependent experiences any of the following triggering events you may apply for or change your coverage within *60 days after* the date of the triggering event. Your new coverage will be effective on an appropriate date based on the circumstances but no later than the following: If you apply and are enrolled by the 15th of the month, your new coverage will be effective on the first day of the following month. If you apply and are enrolled between the 16th and the last day of the month, your new coverage will be effective on the first day of the second following month.

   i. Enrollment or non-enrollment in a QHP through the Marketplace that is unintentional, inadvertent, or erroneous and due to an error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Marketplace or the federal Department of Health and Human Services, its instrumentalities, or a non-Marketplace entity providing enrollment assistance or conducting enrollment activities;

   ii. A QHP sold through the Marketplace has substantially violated a material provision of its contract for coverage;

   iii. A qualified individual or dependent (a) applies for coverage on the Marketplace during the annual open enrollment period or due to a Qualifying Event, is assessed by the Marketplace as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP either after open enrollment has ended or more than 60 days after the qualifying event, or (b) applies for coverage at the state Medicaid or CHIP agency during the annual open enrollment period and is determined ineligible for Medicaid or CHIP after open enrollment has ended;

   iv. Meeting other exceptional circumstances as the Marketplace may provide.

e. Subsidy Eligibility. If you are determined newly eligible or ineligible for Advance Premium Tax Credits or cost-sharing reductions for coverage purchased through the Marketplace, you may apply for or change your coverage within *60 days before or 60 days after* the date of the triggering event. If you apply and are enrolled on or before the date of the triggering event, the effective date of coverage is the first day of the month following the triggering event. If you apply and are enrolled after the date of the triggering event, then the effective date is the first day of the following month.

f. Citizenship. You may apply for coverage within *60 days after* you become a United States citizen or a non-citizen who is lawfully present in the United States. If you apply and are enrolled by the 15th of the month, your new coverage will be effective on the first day of the following month. If you apply and are enrolled between the 16th and the last day of the month, your new coverage will be effective on the first day of the second following month.

g. Gaining or Maintaining Membership in a Federally Recognized Tribe or Status as an Alaska Native Claims Settlement Act (ANCSA) Corporation Shareholder. If you gain or maintain status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, you and your eligible dependents who are on the same Marketplace Application as you, may enroll in a QHP or change from one QHP to another, one time per month, through the Marketplace.

h. Release from Incarceration. You are entitled to a Special Enrollment Period if you are released from incarceration. You may apply for coverage within *60 days before or 60 days after* the date of the triggering event. If you apply and are enrolled on or before the date of the triggering event, the effective date of coverage is the first day of the month following the triggering event. If you apply and are enrolled after the date of the triggering event, then the effective date is the first day of the following month.

i. Gaining Access to Individual Coverage Health Reimbursement Arrangement (ICHRA) or Qualified Small Employer Health Reimbursement Arrangement (QSEHRA). If you gain access to an ICHRA or QSEHRA as an alternative to traditional group health plan coverage, you and your

eligible dependents are entitled to an SEP. The triggering event is the first day on which coverage under the ICHRA or QSEHRA can take effect. If the notice of ICHRA or QSEHRA availability was required to be provided at least 90 days before the beginning of the Contract Year, the eligible individual may elect to enroll in the Plan within *60 days before* the date of the triggering event. If the notice was not required to be provided at least 90 days before the beginning of the Contract Year, the eligible individual may elect to enroll in the Plan within *60 days before or 60 days after* the date of the triggering event.

i. If the ICHRA or QSEHRA starts on January 1st, you should enroll during the Individual annual open enrollment period.

ii. If the ICHRA or QSEHRA starts at any other time of the year, and you enroll before the date of the triggering event coverage will generally become effective on the first day of the month following the triggering event or; if the triggering event is on the first day of a month, on the date of the triggering event.

iii. If you enroll on or after the date of the triggering event coverage will become effective on the first day of the month following enrollment.

V. TERMINATION

All rights and benefits under this Contract will cease at 12:00 a.m. (midnight) on the date coverage terminates unless otherwise stated.

5.1 **Voluntary Termination of Coverage**

a. A Contractholder may voluntarily end coverage at any time by submitting a written request for termination to AvMed. The termination request must be received by us at least 14 days in advance of your requested termination date, and must include the name and Member identification number of each Member whose coverage is to be terminated. If you enrolled through the Marketplace, your termination request will be processed and Premiums will be pro-rated accordingly. If you enrolled outside the Marketplace, termination will be effective on the last day of the month in which your request is received. A voluntary termination request cannot be applied retroactively.

b. Coverage will remain in effect between the date we receive your request and the date coverage ends. You are responsible for paying the Premium due for any period of time we provide coverage until the date coverage terminates, or for any amounts you may otherwise owe us.

c. If you terminate coverage you will not be able to enroll in a new plan until the next annual OEP, unless you qualify for an SEP. Non-payment of Premium does not constitute voluntary termination.

5.2 **Involuntary Termination of Coverage.** AvMed may terminate a Member's coverage for any of the following reasons:

a. Termination for Cause

i. We may terminate any Member's coverage upon 45 days' advance written notice to the Member for the following reasons:

1) fraud, intentional Material Misrepresentation of fact, or intentional omission in applying for coverage under this Contract;

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

3) furnishing to us incorrect or incomplete information for the purpose of obtaining 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.

ii. *Time Limit on Certain Defenses.* 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.

b. Non-Payment of Premiums. If we do not receive payment of the monthly Premium by the Premium due date, or within the Grace Period, coverage will be terminated for all Members for whom Premium payment has not been received, on the last day of the month for which the Premium was received. See Section VI. PREMIUMS, COPAYMENTS, COINSURANCE, DEDUCTIBLES AND OTHER EXPENSES for a description of the Grace Period that applies to your coverage, and associated notices we must provide to you if you do not pay your Premiums.

c. Loss of Eligibility. It is a Contractholder's responsibility to notify us, or the Marketplace if applicable, in writing within 30 days after the date you or your Covered Dependent(s) no longer meet the eligibility requirements described in this Contract. If we receive notice from you within the required 30-day period, we will return any excess Premium you have already paid. If we receive notice from you after the required 30-day period, coverage will be terminated as of a current date and no Premiums will be refunded.

i. Upon the loss of a Contractholder's eligibility, coverage for the Contractholder and the Contractholder's Covered Dependents will end on the last day of the month for which the monthly Premium was received, and while the Contractholder was eligible for coverage.

ii. Upon the loss of a Covered Dependent's eligibility, coverage for the dependent will end on the last day of the month for which the monthly Premium was received, and while the dependent was eligible for coverage.

5.3 **Retroactive Termination.** We will make retroactive adjustments in coverage only up to 30 days from the date we receive a request for retroactive termination. If we receive Premiums for any Member after the date on which that Member's eligibility ceased we will refund them on a pro rata basis, limited to the total unearned Premiums paid for the Member, up to a maximum of 30 days from the date eligibility ceased, less any Claims incurred by us after the effective date of termination. If coverage is terminated due to non-payment of Premiums, or failure to timely notify us of a Member's loss of eligibility, we will not be responsible for Claims we incur in providing benefits under the terms of this Contract after the retroactive effective date of the termination. In such event, we reserve the right to recover an amount equal to the Allowed Amount or Maximum Allowable Payment for any Health Care Services provided after the retroactive effective date of the termination, less any Premiums received by us for such Member's coverage after such date.

5.4 **Reinstatement after Termination for Non-Payment of Premium.** If your coverage is terminated for non-payment of Premium, this Contract may be reinstated solely at AvMed's discretion, and only if we terminated your coverage in error. In that event, the Contract will be reinstated retroactively with no break in coverage to the day following the date your coverage was terminated.

5.5 **Discontinuation of Individual Contract or Products.**

a. We may decide to discontinue this Contract. If we discontinue this Contract, we will provide notice to you at least 90 days prior to the date of non-renewal, and we will offer to each Member the option to purchase any other health benefit plan for Individuals and Families we currently offer in the State of Florida. This action will be taken uniformly without regard to any health-status-related factor of Members or individuals who are or who may become eligible for coverage under this Contract.

b. We may discontinue this Contract if we elect to discontinue all contracts issued by us in the individual market. If we cease to offer coverage for Individuals and Families, we will provide notice to the Office of Insurance Regulation, and to you, at least 180 days prior to the date of non-renewal.

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

This Part explains your Premium pre-payment responsibility under this Contract and your share of the costs for Health Care Services you receive. Members are responsible for paying applicable Deductibles, Copayments or Coinsurance amounts to Health Care Providers for certain services at the time services are rendered. In addition to the information explained in this Part, it is important that you read your Schedule of Benefits to determine your share of the costs for Covered Services.

6.1 **Monthly Premium Payment.** The amount of your initial monthly Premium is indicated on the front cover of this Contract.

a. Your Premium will automatically change if you change contractual underwriting requirements, such as moving to a different geographic area, or if the number of individuals covered under this Contract changes. We will not change your Premium because of Claims filed or due to a change in your health since becoming a Member. Renewal Premiums may be based on your original Premium, age, area of residence, tobacco use, and the type of health benefit plan you select. Your Premium may increase each year on the Contract renewal date due to the increase in any Member's age. We will notify you 30 days in advance of any change in your Premium.

b. If we accept the Premium for a Covered Dependent for a period of time beyond the date, age, or event specified for termination of the Covered Dependent's coverage, that coverage will continue during the Grace Period for which an identifiable Premium was accepted, unless we accepted the Premium because of a misstatement of age, tobacco use or residence.

6.2 **Third-Party Premium Payment**

a. Premium payments must be made by the Contractholder, and we will not accept Premium payments from third-party payers except as required by law and as listed below:

i. a Ryan White HIV/AIDS Program;

ii. an Indian tribe, tribal organization, or urban Indian organization;

iii. a local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf;

iv. a designated representative, acceptable to us, which may include family members and domestic partners;

b. Please contact us at 1-800-477-8768 if you have questions as to whether we will accept Premium payments from any specific third-party.

6.3 **Premium Payment Due Date.** Your first Premium payment is due before the effective date of this Contract. All subsequent Premium payments are payable in advance, or within the Grace Period described below. Failure on our part, for any reason, to provide you with a notice of payment due does not justify your non-payment of Premiums. It is your sole responsibility to submit the monthly Premium by the Premium due date or within the Grace Period.

6.4 **Grace Period.** The Grace Period is the period of time immediately following the date the Premium payment is due, during which your Premiums may be paid without penalty, and coverage under this Contract will remain in effect.

a. If you purchased coverage directly from AvMed, or you purchased coverage through the Marketplace and are not eligible for or elected not to receive Advanced Premium Tax Credits (APTC), this Contract has a 20-day Grace Period. The Grace Period begins on the date the Premium payment is due, and ends at 12:00 a.m. (midnight) on the 20th day immediately following the Premium due date. If any required Premium payment is not received by us on or before the date it is due, it may be paid during the Grace Period.

i. If payment is not received by the last day of the Grace Period, we will terminate this Contract for non-payment of Premium retroactively to the last day of the month for which Premium was paid. We will provide you at least 10 days' written notice, including the reason for termination, prior to the end of the Grace Period.

b. If you purchased coverage through the Marketplace and are receiving APTCs, and you have paid at least one full month's Premium during the Contract Year, this Contract has a 90-day (3-month) Grace Period. The Grace Period begins on the date the Premium payment is due, and ends at 12:00 a.m. (midnight) on the 90th day immediately following the Premium due date. If any required Premium payment is not received by us on or before the date it is due, it may be paid during the Grace Period.

   i. We will pay Claims for Covered Services received during the first month of the Grace Period. We may pend Claims for Covered Services received in the second and third months of the Grace Period. We will continue to collect APTCs on your behalf.

   ii. If Premium payment is not received by the last day of the Grace Period we will terminate this Contract for non-payment of Premium retroactively to the last day of the first month of the Grace Period, and return the APTCs for the second and third months of the Grace Period. We will have no liability for Claims for Covered Services received during the second and third months of the Grace Period. We will provide you at least 10 days' written notice, including the reason for termination, prior to the end of the Grace Period.

6.5 **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 12.10, 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.

a. 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.

b. Family Calendar Year Deductible. The Family Calendar Year Deductible, when applicable, may be satisfied by any combination of two or more Members in a family 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.

6.6 **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 have to pay when you receive these services. Please refer to your Schedule of Benefits for particular Covered Services that are subject to a Copayment or Coinsurance. All applicable Calendar Year Deductible, Copayment or Coinsurance amounts must be satisfied before we will pay any portion of the cost of Covered Services.

6.7 **Calendar Year Out-of-Pocket Maximum.** Subject to Section 12.10, 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.

a. 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.

b. 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.

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

a. non-covered services;

b. Prescription Drug Brand Additional Charges; and

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

6.9 **Estimate of Cost for Services.** You may obtain an estimate of the cost for particular services from In-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 particular service is a Covered Service. 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, 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*, 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 **Primary Care Physicians.** With the AvMed Entrust 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 Entrust Plan In-Network Providers. If you do not choose a PCP yourself, AvMed will select one for you. Primary care services must be received from your designated PCP on record with AvMed. If you receive primary care services from a PCP other than the PCP we have on record for you, the services will not be covered by us, and you will be solely responsible for the cost of such services.

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.

7.3 **Specialty Physicians.** You are entitled to see in-network Specialty Physicians. You must have a referral from your PCP in order to see a Specialty Physician. This means that you must get approval in advance from your PCP before visiting a Specialty Physician in order for services to be covered. Referrals will be processed electronically as Physician-to-Physician transactions, meaning that your PCP will create and send the referral directly to the Specialty Physician electronically. Except as provided for chiropractors, dermatologists, OB/GYNs and podiatrists, if you receive Specialty Physician services without the proper referral from your PCP the services will not be covered by us, and you will be solely responsible for the cost of such services.

7.4 **Provider Directory.** The names and addresses of AvMed Entrust 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 Contractholders. The list of In-Network Providers may also be accessed from AvMed's website at www.avmed.org. In-Network Health Care 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.

7.5 **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.

VIII. ACCESSING COVERED BENEFITS AND SERVICES

8.1 **Covered Benefits and Services.** Members are entitled to receive Covered Benefits and Services only as specified herein, appropriately prescribed or directed by In-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 incorporated herein.

a. Except for Emergency Medical Services and Care as provided in Part IX. COVERED MEDICAL SERVICES, all services must be received from In-Network Providers within the Service Area, and AvMed will have no liability or obligation whatsoever on account of services or benefits sought or received by any Member from any Out-of-Network Provider or other person, institution or organization, unless prior arrangements have been made for the Member and confirmed by written referral or Prior Authorization from AvMed.

b. Primary care services must be received from your designated PCP on record with AvMed. This means that if you receive services from a PCP other than the one we have on record for you, the services will not be covered by us, and you will be solely responsible for the cost of such services.

c. You must have a referral from your PCP before visiting a Specialty Physician, in order for services to be covered. Except as provided for chiropractors, dermatologists, OB/GYNs and podiatrists, if you receive Specialty Physician services without the proper referral from your PCP the services will not be covered by us, and you will be solely responsible for the cost of such services.

d. Members may access participating chiropractors, podiatrists, and OB/GYNs without the need for a referral or Prior Authorization. Coverage for such services is subject to Medical Necessity and utilization management guidelines, as well as any applicable benefit maximums described in Part X. LIMITATIONS OF COVERED MEDICAL SERVICES or Exclusions described in Part XI. EXCLUSIONS FROM COVERED MEDICAL SERVICES.

e. If a Member does not follow the access rules described in this Contract, he risks having the services and supplies received not covered.

8.2 **Member's Responsibility in Seeking Covered Benefits and Services.** Members are solely responsible for selecting a provider when obtaining Health Care Services and for verifying whether that provider is an In-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. It is the Member's responsibility when seeking benefits under this Contract to identify himself as a Member of AvMed and to assure that services received by the Member are rendered by in-network Health Professionals.

8.3 **Decision-Making for Health Care Services.** Any and 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 his

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 his 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. Members acknowledge it is possible that a Member and his Physicians 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 the course of 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 a particular admission or 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.** In order for Health Care Services to be covered under this Contract, such services must meet all of the requirements to be a Covered Benefit or Covered Service, 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, his 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 **Prior Authorization of Services**

a. 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.

b. 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;

xiii. care rendered by Out-of-Network Providers (except for Emergency Medical Services and Care).

c. 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 1-800-477-8768. 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 applicable 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 in-network 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 of, 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. In order 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 as long as 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 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 Contract Dentists, Contract Specialists and Contract Orthodontists as described in Part XVIII. PEDIATRIC DENTAL BENEFITS, LIMITATIONS AND EXCLUSIONS. 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 under contract with AvMed.

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 an in-network 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 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.

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 specified herein. When emergency services are rendered by an Out-of-Network Provider 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. For out-of-network emergency services, AvMed will pay an amount equal to the greater of the three amounts specified below:
   i. The median of the amount negotiated with In-Network Providers for the emergency services furnished;
   ii. The amount for the emergency services calculated using AvMed's Maximum Allowable Payment, which is the same method the Plan generally uses to determine payments for out-of-network services, and applying in-network cost-sharing; or
   iii. The amount that would be paid under Medicare for the Emergency Medical Services and Care.

c. 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 an In-Network 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 an in-network 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 in order 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 in-network 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**, with regard to inpatient admission following Emergency Medical Services and Care.

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

a. Services must be provided under the direction of an in-network 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 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 an in-network 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 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) in order to obtain access to obstetrical or gynecological care from 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 that 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 in an attempt to avoid surgery, and is necessary to carry out 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(ies).** 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 **Out-of-Network Provider Services.** When, in the professional judgment of AvMed's Medical Director, a Member needs Covered Services which require skills or facilities not available from In-Network Providers, and it is in the best interest of the Member to obtain the needed care from an Out-of-Network Provider, upon authorization by the Medical Director, payment not to exceed the Maximum Allowable Payment, will be made for such Covered Services rendered by an Out-of-Network Provider.

9.37 **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.

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

9.39 **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 an in-network Physician in order 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.

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

9.41 **Physician Care: Outpatient**

a. Diagnosis and Treatment. All Health Care Services rendered by in-network Physicians and other in-network Health Professionals are covered when Medically Necessary and when provided at 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*), and consultation and treatment by participating Specialty Physicians. Also included are non-reusable materials and surgical supplies.

b. Preventive and Health Maintenance Services. Services of in-network 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.

9.42 **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 under your medical benefits. See Part XII. PRESCRIPTION MEDICATION BENEFITS, LIMITATIONS AND EXCLUSIONS for additional information about Prescription Medications.

9.43 **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.

9.44 **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 injury or illness.

a. A Member may choose to obtain a second medical opinion from any in-network or out-of-network Physician within the Service Area. If an in-network Physician is chosen, the applicable office visit cost-sharing will apply. If an out-of-network Physician is chosen, Prior Authorization is required, and the Member is responsible for 40% of the amount of the Maximum Allowable Payment associated with consultation.

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 particular diagnosis or treatment to three per calendar year, if AvMed deems additional opinions to be an unreasonable over-utilization by the Member.

9.45 **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 of, 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.

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

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

9.48 **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 an in-network 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.

9.49 **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 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.

9.50 **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.

9.51 **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.

9.52 **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.

9.53 **Vision Services - Pediatric.** 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 in-network 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*.

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 (Essential Health Benefits)**

a. 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.

b. 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 **Drug Infusion Therapy.** 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. Third-party Copayment assistance (sometimes also referred to as a "copay card" or "copay coupon") provided by a drug manufacturer toward your cost-sharing 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.

10.6 **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.

10.7 **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.

10.8 **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.

10.9 **Inpatient acute Rehabilitation Services** received in a Hospital are limited to 30 days per calendar year.

10.10 **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.

10.11 **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.

10.12 **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 in an attempt to avoid surgery and when necessary to carry out normal activities of daily living, excluding sports activities. Replacements are covered only when Medically Necessary due to a change in bodily configuration.

10.13 **Other Health Care Facility(ies).** 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.

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

10.15 **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.

10.16 **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.

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

10.18 **Skilled Nursing Facilities and Rehabilitation Centers.** See **Other Health Care Facility(ies)** above.

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

10.20 **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.

10.21 **Transplant Services.** Transplant services are limited to 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 has to 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.

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

10.23 **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 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. 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 engaging 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 **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, hand held showers, paraffin baths, bath mats, 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.

11.17 **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.

11.18 **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.

11.19 **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.

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

11.21 **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. eye glasses 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.

11.22 **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.

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

11.24 **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 in order to be covered. Coverage guidelines are available at www.avmed.org.

11.25 **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.

11.26 **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.

11.27 **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.

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

11.29 **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.

11.30 **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.

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

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

11.33 **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.

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

11.35 **Medical care or surgery** not rendered by an In-Network Provider, except for Emergency Medical Services and Care.

11.36 **Medical supplies** including pre-fabricated 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 **Out-of-Network Providers.** Any treatment or service from an Out-of-Network Provider, except in the case of an emergency or when specifically pre-authorized by AvMed, including Hospital care from an out-of-network Physician or Hospital if elected by a Member. In such circumstances, coverage is excluded for the entire episode of care, except when the admission was due to an emergency or with the prior written authorization of AvMed.

11.43 **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.

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

11.45 **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.

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

11.47 **Professional Services.** Non-patient-specific professional services associated with machine or other testing including oversight of a medical laboratory to assure timeliness, reliability, and usefulness of test results and overseeing calibration of laboratory testing equipment.

11.48 **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.

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

11.50 **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.

11.51 **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.

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

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

11.54 **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.

11.55 **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.

11.56 **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.

11.57 **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 eye glasses) and hearing aids, including the professional fee for fitting them, are not covered.

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

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

11.60 **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.

11.61 **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.

11.62 **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.

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

11.64 **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.

11.65 **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.

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

11.67 **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.

11.68 **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.

11.69 **Wigs** or cranial prostheses.

11.70 **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 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 different levels of cost-sharing for medications within therapeutic classes. As new medications become available, they may be considered excluded until they have been reviewed by AvMed's Pharmacy and Therapeutics Committee. Specific medications on the Formulary List and their placement in a given 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 U.S. Food and Drug Administration (FDA), for which the duration of therapy can reasonably be expected to exceed one year, as determined by the Pharmacy Benefits Manager.

h. **Specialty Medications** are high cost 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 **Pharmacy Coverage Criteria.** Your Prescription Medication coverage includes outpatient medications (including certain contraceptives) that require a prescription, are prescribed by a Physician in accordance with AvMed's Coverage Criteria, and are filled at an In-Network Pharmacy. AvMed reserves the right to make changes in Coverage Criteria for covered products and services.

12.3 **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 the AvMed 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.

12.4 **Cost-Sharing and Refilling Prescriptions.** Your retail Prescription Drug coverage includes up to a 30-day supply of a medication for the cost-sharing amounts shown in your Schedule of Benefits. Your prescription may be refilled via retail or mail order after 75% of your previous fill has been used and subject to a maximum of 13 refills per year. You also have the opportunity to obtain a 90-day supply of Prescription Medications used for chronic Conditions including asthma, cardiovascular disease, and diabetes, from a retail In-Network Pharmacy or via mail order for the applicable cost-sharing per 30-day supply.

12.5 **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.

12.6 **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 (as well as the Brand Additional Charge if you or your Physician choose a Brand Medication when a Generic equivalent is available) shown in your Schedule of Benefits. Your Physician should submit prescriptions for Specialty Medications to AvMed's in-network specialty pharmacy.

12.7 **Mail Services for Prescriptions.** Mail-order Prescription Drug coverage includes up to a 90-day supply of a routine Maintenance Medication 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. Mail service is a benefit option for Maintenance Medications needed for chronic or long-term health Conditions. It is often best to get an initial prescription filled at your retail In-Network Pharmacy. Ask your Physician for an additional prescription for a 60-90-day supply of your medication to be ordered through mail service. Please refer to your Schedule of Benefits for cost-sharing amounts for Prescription Medications ordered through mail services.

12.8 **Prescription Medication Benefits Disclaimer.** Filling a prescription at a pharmacy is not a Claim for benefits and is not subject to the Claims and Appeals procedures. However, any Prescription Medications that require Prior Authorization will be treated as a Claim for benefits subject to the Claims and Appeals Procedures, as outlined in this Contract.

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

a. **Allergy serums**; however, medications administered by the Attending Physician to treat the acute phase of an illness, and chemotherapy for cancer patients, are covered in accordance with this Contract;

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 five years of age with a non-fluorinated water supply);

e. **Experimental or Investigational drugs** (except as required by law) (See Part XI. EXCLUSIONS FROM COVERED MEDICAL SERVICES);

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, 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 appetite suppressants** and products for the purpose of weight loss;

o. **Prescription and non-prescription vitamins and minerals** except prenatal vitamins; and

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

12.10 **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 Calendar Year Deductible, Copayment, or Coinsurance amounts for any Specialty Medications, you will not receive credit toward your Calendar Year Out-of-Pocket Maximum or Calendar Year Deductible for any such assistance you use.

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 Grievance'. 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: 1-800-477-8768
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.** Each time we process a Claim submitted by you or your Health Care Provider, we explain how we processed it in the form of an Explanation of Benefits (EOB). The EOB is not a bill. It simply explains how your benefits were applied to that particular Claim. It includes the date you received the service, the amount billed, the amount covered, the amount we paid, and any balance you're responsible for paying the Health Care Provider. Each time you receive an EOB, review it closely and compare it to the receipt or statement from the Health Care Provider. 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 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: 1-800-477-8768
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, taking into account 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 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, taking into account 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 of time 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 of time or number of treatments previously authorized, will be decided as soon as possible, taking into account 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 of time 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 of 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 actually 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 we notify the Claimant, before the expiration of the initial 30-day period, 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 take into account all comments, documents, records and other information the Claimant submitted relating to the Claim, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

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 person 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 particular 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 of 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 1-800-477-8768 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.

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 or not 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 actually 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.** You are responsible for providing us with written information concerning 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 step-parent'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 also 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. When you are eligible for Medicare, AvMed coordinates your benefits under this plan with the benefits Medicare pays. If you are eligible but not covered under Medicare, we may coordinate your benefits under this Plan with the benefits Medicare would pay had you enrolled. 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.

a. If you are eligible for 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 eligible for 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 eligible for 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 coverage, 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 in order 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. Members. Members will not be liable to AvMed or Participating Providers except as specifically set forth herein, provided all procedures set forth herein are followed.

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

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 his 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 **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.

17.2 **Changes to Coverage and Benefits.** 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 Contractholder. In the event the amendment is unacceptable to the Contractholder, the Contractholder 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 Contractholder unless such amendment is evidenced in writing and signed by a duly authorized officer of AvMed.

17.3 **Changes to Premium.** We may modify the Premium rates at any time, without your consent, upon at least 30 days' prior notice to the Contractholder, subject to the approval of the Florida Office of Insurance Regulation. Payments submitted to us following receipt of any such written notice of modification constitutes acceptance by the Contractholder of any such modification.

17.4 **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.

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

17.6 **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.

17.7 **Confidentiality**

a. Except as otherwise specifically provided herein, and except as may be required in order 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.

17.8 **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.

17.9 **Entire Agreement.** This Contract, including the Application for Coverage 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 all Members, AvMed, and any of their subsidiaries, affiliates, successors, heirs, and permitted assignees. All prior negotiations, agreements, and understandings are superseded hereby.

17.10 **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.

17.11 **Identification Cards.** Cards issued by AvMed to Members pursuant to this Contract are for purposes 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 actually been paid and accepted by AvMed. Please carry your Identification Card with you at all times, and present it before Covered Services are rendered. If your Identification Card is missing, lost, or stolen, contact AvMed's Member Engagement Center at 1-800-477-8768, 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.

17.12 **Modification of AvMed Provider Network and Participation Status.** The AvMed Entrust 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 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.

17.13 **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.

17.14 **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 Contractholder's latest address on enrollment forms actually delivered to us.

17.15 **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.

17.16 **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.

17.17 **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, in order 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.

17.18 **Third-Party Beneficiary.** This Contract was issued by AvMed to the Contractholder, and was entered into solely and specifically for the benefit of AvMed and the Contractholder. The terms and provisions of the Contract will be binding solely upon, and inure solely to the benefit of, AvMed and the Contractholder, 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 Contractholder hereby specifically express their intent that Health Care Providers that have not entered into contracts with AvMed to render the professional Health Care Services set forth herein will not be third-party beneficiaries under this Contract.

XVIII. PEDIATRIC DENTAL BENEFITS, LIMITATIONS AND EXCLUSIONS

18.1 **Introduction.** We are pleased to welcome you to this individual DeltaCare USA dental plan. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the Dentist, but to see the Dentist on a regular basis.

18.2 **Using this Section of Your Contract.** This Section of your Contract discloses the terms and conditions of your dental coverage and is designed to help you make the most of your dental plan. It will help you understand how this DeltaCare USA dental plan works and how to obtain dental care. Please read this Section completely and carefully. Keep in mind that when used in this Section, the words "you" and "your" mean Enrollees who are covered under this dental plan. Use of the words "we," "us" and "our" in this Section of your Contract always refer to Delta Dental Insurance Company (Delta Dental).

18.3 **Contact Delta Dental.** If you have any questions about your dental coverage that are not answered here, please visit our website at deltadentalins.com or call our Customer Service Center at 888-857-0337. If you prefer to write to us with your question(s), please mail your inquiry to the address shown below.

18.4 **Identification Number.** Please provide the Enrollee's identification ('ID') number to your Dentist whenever you receive dental services. ID cards are not required. If you wish to have an ID card, you may obtain one by visiting our website at deltadentalins.com.

DeltaCare USA Customer Service
P.O. Box 1803
Alpharetta, GA 30023
Identification Number

18.5 **Dental Benefits Definitions.** The following are definitions of words that have special or technical meanings under this Section of your Contract.

a. Adult Benefits: dental services under this Contract for people age 19 years and older.
b. Authorization: the process by which Delta Dental determines if a procedure or treatment is a referable Benefit under the dental plan.
c. Benefits: covered dental services provided under the terms of this Contract.
d. Calendar Year: the 12 months of the year from January 1 through December 31.
e. Contract Dentist: a Dentist who provides services in general dentistry and who has agreed to provide Benefits under the plan.
f. Contract Orthodontist: a Dentist who specializes in orthodontics and who has agreed to provide Benefits under the plan.
g. Contract Specialist: a Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under the plan.
h. Copayment: the amount listed in the Schedules and charged to an Enrollee by a Contract Dentist or Contract Specialist for the Benefits provided under the plan. Copayments must be paid at the time treatment is received.
i. Dentist: a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.
j. Effective Date: the original date the plan starts.
k. Eligible Dependent: a person who is a dependent of an Eligible Primary and considered to be a Qualified Individual by the Exchange. Eligible Dependents are eligible for either Pediatric Benefits or Adult Benefits as described in this Policy.
l. Eligible Pediatric Individual: a person who is considered to be a Qualified Individual by the Exchange. Eligible Pediatric Individuals are eligible for Pediatric Benefits as described in this Policy.

m. Eligible Primary: a person who is considered to be a Qualified Individual by the Exchange. Eligible Primaries are eligible for either Pediatric Benefits or Adult Benefits as described in this Policy.

n. Emergency Services: only those dental services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Enrollee's health in serious jeopardy.

o. Enrollee: an Eligible Primary ("Primary Enrollee"), Eligible Dependent ("Dependent Enrollee") or Eligible Pediatric Individual ("Pediatric Enrollee") enrolled under this Policy to receive Benefits.

p. Essential Health Benefits ("Pediatric Benefits"): for the purposes of this Policy, Essential Health Benefits are certain pediatric oral services that are required to be included in this Policy 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.

q. Exchange: the Florida Federally-Facilitated Health Exchange.

a. Open Enrollment Period: the period of the year that the Exchange has established when the Primary Enrollee may change coverage selections for the next Policy Year.

b. Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the Limitations and Exclusions of this Contract.

c. Out-of-Network: treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits under the terms of this Contract.

d. Out-of-Pocket Maximum: the maximum amount that an Enrollee will pay for Benefits during the calendar year. Refer to Schedule A attached to this Section of your Contract for details.

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

f. Qualified Individual: an individual determined by the Exchange to be eligible to enroll through the Exchange.

g. Single Procedure: a dental procedure that is assigned a separate Procedure Code.

h. Specialist Services: services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics or pediatric dentistry. Specialist Services must be authorized by Delta Dental.

18.2 **Eligibility for Benefits.** This dental plan includes Pediatric Benefits. Enrollees are eligible for Pediatric Benefits according to the requirements listed below.

a. Pediatric Benefits, as described in this Section, are available to Enrollees through the end of the month in which the Enrollee turns age 19.

18.3 **Overview of Benefits.** This information will help you understand how this dental plan works and how to make it work best for you.

a. What is the DeltaCare USA Plan? The DeltaCare USA plan provides Pediatric Benefits through a network of Contract Dentists in the state of Florida. These Dentists are screened to ensure that our standards of quality, access and safety are maintained. The network is composed of established dental professionals. When you visit your assigned Contract Dentist, you pay only the applicable Copayment for Benefits. There are no deductibles, lifetime maximums or claim forms.

b. Benefits, Limitations and Exclusions. This plan provides the Benefits described in the Schedules that are a part of this Contract. Benefits are only available in the state of Florida. The services are performed as deemed appropriate by your attending Contract Dentist.

c. Copayments and Other Charges

i. You are required to pay any Copayments listed in the Schedules attached to this Contract. Copayments are paid directly to the Dentist who provides treatment. Charges for broken appointments and visits after normal visiting hours are listed in the Schedules attached to this Contract.

ii. In the event that we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. If you have not received Authorization for treatment from an Out-of-Network Dentist, and we fail to pay that Out-of-Network Dentist, you may be liable to that Dentist for the cost of services. For further clarification, see "Emergency Services" and "Specialist Services."

18.4 **How to use the DeltaCare USA Plan/Choice of Contract Dentist**

a. Delta Dental will provide Contract Dentists at convenient locations during the term of this Contract. Upon enrollment, Delta Dental will assign the Enrollees to one Contract Dentist facility. The Contractholder may request changes to the assigned Contract Dentist facility by directing a request to the Customer Service Center at 888-857-0337. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. The change must be requested prior to the 21st of the month to become effective on the first day of the following month.

b. We will provide you written notice of assignment to another Contract Dentist facility near the Enrollee's home if: 1) a requested facility is closed to further enrollment; 2) a chosen Contract Dentist facility withdraws from the plan; or 3) an assigned facility requests, for good cause, that the Enrollee be re-assigned to another facility.

c. All treatment in progress must be completed before you change to another Contract Dentist facility. For example, this would include: 1) partial or full dentures for which final impressions have been taken; 2) completion of root canals in progress; and 3) delivery of crowns when teeth have been prepared.

d. All services which are Benefits will be rendered at the Contract Dentist facility assigned to the Enrollee. Delta Dental will have no obligation or liability with respect to services rendered by Out-of-Network Dentists, with the exception of Emergency Services or Specialist Services referred by a Contract Dentist, and authorized by Delta Dental. All authorized Specialist Services claims will be paid by Delta Dental less any applicable Copayments. A Contract Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services.

e. If your assigned Contract Dentist facility terminates participation in the plan, that Contract Dentist facility will complete all treatment in progress as described above.

f. Emergency Services. The assigned Contract Dentist facility maintains a 24-hour Emergency Services system seven (7) days a week. If Emergency Services are needed, you should contact the Contract Dentist facility whenever possible. If you are unable to reach the Contract Dentist facility for Emergency Services, you should call the Customer Service Center at 888-857-0337 for assistance in obtaining urgent care. During non-business hours or if you require Emergency Services and are 35 miles or more from your assigned Contract Dentist facility, you do not need to call for referral and may seek treatment from a Dentist other than at the assigned Contract Dentist facility. You are responsible for the Copayment(s) for any treatment received due to an emergency. Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the assigned Contract Dentist facility.

g. Specialist Services

i. Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry must be: 1) referred by the assigned Contract Dentist; and 2) authorized by us. You pay the specified Copayment. (Refer to the Schedules attached to this Contract.)

ii. If you require Specialist Services and there is no Contract Specialist to provide these services within 35 miles of your home address, the assigned Contract Dentist must receive Authorization from Delta Dental to refer you to an Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist that are not authorized by Delta Dental will not be covered.

iii. If the services of a Contract Orthodontist are needed, please refer to the Schedules attached to this Contract to determine Benefits.

h. Claims for Reimbursement. Claims for covered Emergency Services or authorized Specialist Services should be sent to us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit

the claim within that time. All claims must be received within one (1) year of the treatment date. The address for claims submission is Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

i. Processing Policies. The dental care guidelines for the DeltaCare USA plan explain to Contract Dentists what services are covered under this Contract. Contract Dentists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist that fall under the scope of Benefits of this Contract are provided subject to any Copayments. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a specialist. An Enrollee may contact Delta Dental's Customer Service Center at 888-857-0337 for information regarding the dental care guidelines for DeltaCare USA.

18.5 **Enrollee Complaint Procedure**

a. Delta Dental will provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call the Customer Service Center at 888-857-0337, or the complaint may be addressed in writing to:

Quality Management Department
P.O. Box 1860
Alpharetta, GA 30023

b. Written communication must include: 1) the name of the patient; 2) the name, address, telephone number and ID number of the Enrollee; and 3) the Dentist's name and facility location.

c. Within 10 business days of the receipt of any complaint, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a Dentist for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint or will provide a written explanation if additional time is required to report on the complaint.

d. A review of the decision will be undertaken if a written request for an appeal of the determination is made within 30 days of the date of the written determination. Delta Dental will undertake a full and fair review upon request. Delta Dental may require additional documents, as it deems necessary, in making such a review. Delta Dental will provide a written response to you within 30 days after receipt of the appeal and supporting documentation or a written explanation if additional time is required to issue the results.

e. The State of Florida Department of Financial Services may be contacted at any time, concerning any complaint or request for assistance, by writing to 200 East Gaines St., Tallahassee, FL 32399-0322, or by calling the Office's toll-free consumer hotline: 1-877-693-5236.

18.6 **Extension of Benefits.**

a. Benefits will continue to be provided for dental services provided to a patient who is totally disabled when coverage ends if:

i. the Dentist recommends the services to the patient and the services began while the coverage was in effect;

ii. the dental services to be performed by the dentist, if the dentist:

1) prepared the abutment teeth for the completion of installation of prosthetic devices;

2) made an impression;

3) prepared the tooth for cast restoration; or

4) opened the pulp chamber before the insurance ends and the device is installed or treatment was finished within 90 days after the termination of coverage;

iii. the services are provided within 90 days after the patient's coverage ended, and the coverage did not end because the patient (or, in the case of a dependent child, the child's parent) voluntarily terminated coverage.

b. The extension of Benefits ends at the earlier of:
   i. the end of the 90-day period in 3) above; or
   ii. the date the patient becomes covered under a succeeding policy.

c. However, if coverage for the dental services described in this *Extension of Benefits* provision are excluded by the succeeding policy through the use of an elimination period or limitations and the patient is not covered by the succeeding policy, the extension of Benefits does not terminate.

d. All contractual Limitations, Exclusions or reductions that would have applied to the specific dental services had this coverage not terminated apply during the extension of Benefits.

18.7 **General Provisions of Your Dental Plan**

a. Third Party Administrator ("TPA"). Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Contract. Any TPA providing such services or receiving such information will enter into a separate business associate agreement with Delta Dental providing that the TPA will meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

b. Impossibility of Performance. Neither party (Contractholder or Delta Dental) will be liable to the other or be deemed to be in breach of this Contract for any failure or delay in performance arising out of causes beyond its reasonable control. Such causes are strictly limited to include acts of God or of a public enemy, explosion, fires or unusually severe weather. Dates and times of performance will be extended to the extent of the delays excused by this paragraph, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay.

c. Non-Discrimination. 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.
   i. 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
      3) If you need these services, contact our Customer Service Center at 888-857-0337.
   ii. 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.

DeltaCare USA
17871 Park Plaza Drive, Ste. 200
Cerritos, CA 90703
Telephone Number: 888-857-0337
Website Address: deltadentalins.com

iii. 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)

iv. Complaint forms are available ahttp://www.hhs.gov/ocr/office/file/index.htm.

18.8 **Description of Pediatric Dental Coverage for Catastrophic Plan SCHEDULE A**

a. The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the Limitations and Exclusions of the DeltaCare USA Plan ("Plan"). Please refer to Schedule B for further clarification of Benefits. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.

b. Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association® ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D0100–D0999 I. DIAGNOSTIC			
- Benefits in this category are not subject to the Plan Deductible described in your <EOC NAME>.			
D0999	Unspecified diagnostic procedure, by report	No cost	*Includes office visit, per visit (in addition to other services)*
D0120	Periodic oral evaluation - established patient	No cost	*1 of (D0120, D0150, D0180) per 6 months*
D0140	Limited oral evaluation - problem focused	No cost	*1 of (D0140, D0170) per Contract Dentist per 6 months*
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No cost	
D0150	Comprehensive oral evaluation - new or established patient	No cost	*1 of (D0120, D0150, D0180) per 6 months*
D0160	Detailed and extensive oral evaluation - problem focused, by report	No cost	
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No cost	*1 of (D0140, D0170) per Contract Dentist per 6 months*
D0180	Comprehensive periodontal evaluation - new or established patient	No cost	*1 of (D0120, D0150, D0180) per 6 months*
D0210	Intraoral - complete series of radiographic images	No cost	*1 series per 60 months*
D0220	Intraoral - periapical first radiographic image	No cost	
D0230	Intraoral - periapical each additional radiographic image	No cost	
D0240	Intraoral - occlusal radiographic image	No cost	
D0270	Bitewing - single radiographic image	No cost	*1 set per 6 months*
D0272	Bitewings - two radiographic images	No cost	*1 set per 6 months*
D0273	Bitewings - three radiographic images	No cost	*1 set per 6 months*

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D0274	Bitewings - four radiographic images	No cost	*1 set per 6 months*
D0277	Vertical bitewings - 7 to 8 radiographic images	No cost	*1 set per 6 months*
D0330	Panoramic radiographic image	No cost	*1 image per 60 months*
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	No cost	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No cost	
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	No cost	
D0419	Assessment of salivary flow by measurement	No cost	*1 per 12 months*
D0460	Pulp vitality tests	No cost	
D0470	Diagnostic casts	No cost	
D0601	Caries risk assessment and documentation, with a finding of low risk	No cost	*1 of (D0601, D0602, D0603) per 36 months when performed by the same Contract Dentist or office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No cost	*1 of (D0601, D0602, D0603) per 36 months when performed by the same Contract Dentist or office*
D0603	Caries risk assessment and documentation, with a finding of high risk	No cost	*1 of (D0601, D0602, D0603) per 36 months when performed by the same Contract Dentist or office*
D1000-D1999 II. PREVENTIVE			
- Benefits in this category are not subject to the Plan Deductible described in your <EOC NAME>.			
D1110	Prophylaxis - adult	No cost	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1120	Prophylaxis - child	No cost	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1206	Topical application of fluoride varnish	No cost	*1 of (D1206, D1208) per 6 months*
D1208	Topical application of fluoride - excluding varnish	No cost	*1 of (D1206, D1208) per 6 months*
D1351	Sealant - per tooth	No cost	*Permanent molars without restorations or decay; 1 per 36 months*
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No cost	*Permanent molars without restorations or decay; 1 per 36 months*
D1354	Interim caries arresting medicament application - per tooth	No cost	*1 per 6 months*
D1510	Space maintainer - fixed, unilateral - per quadrant	No cost	
D1516	Space maintainer - fixed - bilateral, maxillary	No cost	
D1517	Space maintainer - fixed - bilateral, mandibular	No cost	
D1520	Space maintainer - removable, unilateral - per quadrant	No cost	
D1526	Space maintainer - removable - bilateral, maxillary	No cost	
D1527	Space maintainer - removable - bilateral, mandibular	No cost	

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No cost	
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No cost	
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No cost	
D1556	Removal of fixed unilateral space maintainer - per quadrant	No cost	*Included in case by dentist/dental office who placed appliance; a separate charge applies for service provided by a dentist other than the original treating dentist/dental office*
D1557	Removal of fixed bilateral space maintainer - maxillary	No cost	*Included in case by dentist/dental office who placed appliance; a separate charge applies for service provided by a dentist other than the original treating dentist/dental office*
D1558	Removal of fixed bilateral space maintainer - mandibular	No cost	*Included in case by dentist/dental office who placed appliance; a separate charge applies for service provided by a dentist other than the original treating dentist/dental office*
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	No cost	*1 per quadrant per lifetime; Age 8 and under*
D2000-D2999 III. RESTORATIVE			
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.			
- Replacement of crowns, inlays and onlays requires the existing restoration to be 60+ months old.			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D2140	Amalgam - one surface, primary or permanent	$68	
D2150	Amalgam - two surfaces, primary or permanent	$84	
D2160	Amalgam - three surfaces, primary or permanent	$104	
D2161	Amalgam - four or more surfaces, primary or permanent	$121	
D2330	Resin-based composite - one surface, anterior	$81	
D2331	Resin-based composite - two surfaces, anterior	$100	
D2332	Resin-based composite - three surfaces, anterior	$124	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$147	
D2510	Inlay - metallic - one surface	$413	*Base metal is the benefit; 1 per 60 months*
D2520	Inlay - metallic - two surfaces	$482	*Base metal is the benefit; 1 per 60 months*
D2530	Inlay - metallic - three or more surfaces	$502	*Base metal is the benefit; 1 per 60 months*

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D2542	Onlay - metallic - two surfaces	$544	*Base metal is the benefit; 1 per 60 months*
D2543	Onlay - metallic - three surfaces	$570	*Base metal is the benefit; 1 per 60 months*
D2544	Onlay - metallic - four or more surfaces	$687	*Base metal is the benefit; 1 per 60 months*
D2740	Crown - porcelain/ceramic	$785	*1 per 60 months*
D2750	Crown - porcelain fused to high noble metal	$753	*1 per 60 months*
D2751	Crown - porcelain fused to predominantly base metal	$625	*1 per 60 months*
D2752	Crown - porcelain fused to noble metal	$673	*1 per 60 months*
D2753	Crown - porcelain fused to titanium and titanium alloys	$753	*1 per 60 months*
D2780	Crown - 3/4 cast high noble metal	$606	*1 per 60 months*
D2781	Crown - 3/4 cast predominantly base metal	$567	*1 per 60 months*
D2782	Crown - 3/4 cast noble metal	$588	*1 per 60 months*
D2783	Crown - 3/4 porcelain/ceramic	$619	*1 per 60 months*
D2790	Crown - full cast high noble metal	$665	*1 per 60 months*
D2791	Crown - full cast predominantly base metal	$577	*1 per 60 months*
D2792	Crown - full cast noble metal	$620	*1 per 60 months*
D2794	Crown - titanium and titanium alloys	$683	*1 per 60 months*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$53	*1 per 6 months; included at no additional cost within 12 months of placement by the same Contract Dentist/office*
D2920	Re-cement or re-bond crown	$55	*1 per 6 months; included at no additional cost within 12 months of placement by the same Contract Dentist/office*
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$203	*1 per 60 months; through age 14*
D2930	Prefabricated stainless steel crown - primary tooth	$147	*1 per 60 months; through age 14*
D2931	Prefabricated stainless steel crown - permanent tooth	$175	*1 per 60 months; through age 14*
D2940	Protective restoration	$63	
D2950	Core buildup, including any pins when required	$143	*1 per 60 months*
D2951	Pin retention - per tooth, in addition to restoration	$39	
D2954	Prefabricated post and core in addition to crown	$176	*Includes canal preparation; 1 per 60 months*
D2980	Crown repair necessitated by restorative material failure	$155	
D2981	Inlay repair necessitated by restorative material failure	$143	
D2982	Onlay repair necessitated by restorative material failure	$320	
D2983	Veneer repair necessitated by restorative material failure	$196	

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D2990	Resin infiltration of incipient smooth surface lesions	$85	*1 per 36 months*
D3000-D3999 IV. ENDODONTICS			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$125	*If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure.*
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$125	*If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure.*
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$146	*1 per tooth per lifetime; primary incisor up to age 6, primary molars up to age 11*
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$174	*1 per tooth per lifetime; primary incisor up to age 6, primary molars up to age 11*
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$497	*Root canal*
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$577	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$721	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$87	
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$290	
D3333	Internal root repair of perforation defects	$144	
D3346	Retreatment of previous root canal therapy - anterior	$601	
D3347	Retreatment of previous root canal therapy - premolar	$659	
D3348	Retreatment of previous root canal therapy - molar	$771	
D3351	Apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	$233	
D3352	Apexification/recalcification - interim medication replacement	$121	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$323	
D3355	Pulpal regeneration - initial visit	$234	

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D3356	Pulpal regeneration - interim medication replacement	$270	
D3357	Pulpal regeneration - completion of treatment	$398	
D3410	Apicoectomy - anterior	$423	
D3421	Apicoectomy - premolar (first root)	$546	
D3425	Apicoectomy - molar (first root)	$626	
D3426	Apicoectomy (each additional root)	$195	
D3427	Periradicular surgery without apicoectomy	$130	
D3430	Retrograde filling - per root	$130	
D3450	Root amputation - per root	$290	
D3920	Hemisection (including any root removal), not including root canal therapy	$280	
D4000-D4999 V. PERIODONTICS			
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$333	*1 per 36 months per quadrant*
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$200	*1 per 36 months per quadrant*
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$200	*1 per 36 months*
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$429	*1 per 36 months per quadrant*
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$295	*1 per 36 months per quadrant*
D4249	Clinical crown lengthening - hard tissue	$413	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$630	*1 per 36 months per quadrant*
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$413	*1 per 36 months per quadrant*
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	$282	*1 per 36 months*
D4270	Pedicle soft tissue graft procedure	$456	
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$576	

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$325	*1 per 36 months*
D4276	Combined connective tissue and double pedicle graft, per tooth	$538	*1 per 36 months*
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	$489	
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$367	
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	$346	
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	$195	*1 per 36 months*
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$137	*1 per quadrant during any 24 consecutive months*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$93	*1 per quadrant during any 24 consecutive months*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$57	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$57	*1 per lifetime*
D4910	Periodontal maintenance	$73	*4 per 12 months combined with prophylaxis (D1110, D1120) after the completion of active periodontal therapy*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$51	*1 per Contract Dentist*
D5000-D5899 VI. PROSTHODONTICS (removable)			
- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.			
- Replacement of a denture or a partial denture requires the existing denture to be 60+ months old.			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D5110	Complete denture - maxillary	$849	*1 per 60 months*
D5120	Complete denture - mandibular	$849	*1 per 60 months*
D5130	Immediate denture - maxillary	$934	*1 per 60 months*

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D5140	Immediate denture - mandibular	$934	*1 per 60 months*
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$688	*1 per 60 months*
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$688	*1 per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$929	*1 per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$929	*1 per 60 months*
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$826	*1 per 60 months*
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$826	*1 per 60 months*
D5223	immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$1,115	*1 per 60 months*
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$1,115	*1 per 60 months*
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	$565	*1 per 60 months*
D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	$565	*1 per 60 months*
D5284	Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	$508	*1 per 60 months*
D5286	Removable unilateral partial denture - one piece resin (including clasps and teeth) - per quadrant	$508	*1 per 60 months*
D5410	Adjust complete denture - maxillary	$49	
D5411	Adjust complete denture - mandibular	$49	
D5421	Adjust partial denture - maxillary	$49	
D5422	Adjust partial denture - mandibular	$49	
D5511	Repair broken complete denture base, mandibular	$114	
D5512	Repair broken complete denture base, maxillary	$114	
D5520	Replace missing or broken teeth - complete denture (each tooth)	$88	
D5611	Repair resin partial denture base, mandibular	$99	
D5612	Repair resin partial denture base, maxillary	$99	
D5621	Repair cast partial framework, mandibular	$137	
D5622	Repair cast partial framework, maxillary	$137	

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D5630	Repair or replace broken retentive clasping materials - per tooth	$125	
D5640	Replace broken teeth - per tooth	$88	
D5650	Add tooth to existing partial denture	$104	
D5660	Add clasp to existing partial denture - per tooth	$125	
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$399	
D5710	Rebase complete maxillary denture	$252	*1 per 36 months (6 months after initial placement)*
D5720	Rebase maxillary partial denture	$253	*1 per 36 months (6 months after initial placement)*
D5721	Rebase mandibular partial denture	$253	*1 per 36 months (6 months after initial placement)*
D5730	Reline complete maxillary denture (chairside)	$175	*1 per 36 months (6 months after initial placement)*
D5731	Reline complete mandibular denture (chairside)	$175	*1 per 36 months (6 months after initial placement)*
D5740	Reline maxillary partial denture (chairside)	$175	*1 per 36 months (6 months after initial placement)*
D5741	Reline mandibular partial denture (chairside)	$175	*1 per 36 months (6 months after initial placement)*
D5750	Reline complete maxillary denture (laboratory)	$225	*1 per 36 months (6 months after initial placement)*
D5751	Reline complete mandibular denture (laboratory)	$225	*1 per 36 months (6 months after initial placement)*
D5760	Reline maxillary partial denture (laboratory)	$223	*1 per 36 months (6 months after initial placement)*
D5761	Reline mandibular partial denture (laboratory)	$223	*1 per 36 months (6 months after initial placement)*
D5850	Tissue conditioning, maxillary	$104	
D5851	Tissue conditioning, mandibular	$104	
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered			
D6000-D6199 VIII. IMPLANT SERVICES			
- Includes adjustments, if needed, for the first six months after placement, if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the implant was originally delivered.			
- Replacement of a retainer, pontic, or stress breaker requires the existing bridge to be 60+ months old.			
- FPD, as referenced below, stands for fixed partial denture.			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D6010	Surgical placement of implant body: endosteal implant	$1,166	*1 per 60 months*
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$875	*1 per 60 months*
D6040	Surgical placement: eposteal implant	$3,160	*1 per 60 months*
D6050	Surgical placement: transosteal implant	$2,050	*1 per 60 months*

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D6055	Connecting bar - implant supported or abutment supported	$1,412	*1 per 60 months*
D6056	Prefabricated abutment - includes modification and placement	$455	*1 per 60 months*
D6057	Custom fabricated abutment - includes placement	$556	*1 per 60 months*
D6058	Abutment supported porcelain/ceramic crown	$994	*1 per 60 months*
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$903	*1 per 60 months*
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$751	*1 per 60 months*
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$808	*1 per 60 months*
D6062	Abutment supported cast metal crown (high noble metal)	$798	*1 per 60 months*
D6063	Abutment supported cast metal crown (predominantly base metal)	$693	*1 per 60 months*
D6064	Abutment supported cast metal crown (noble metal)	$745	*1 per 60 months*
D6065	Implant supported porcelain/ceramic crown	$933	*1 per 60 months*
D6066	Implant supported crown - porcelain fused to high noble alloys	$918	*1 per 60 months*
D6067	Implant supported crown - high noble alloys	$869	*1 per 60 months*
D6068	Abutment supported retainer for porcelain/ceramic FPD	$847	*1 per 60 months*
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$836	*1 per 60 months*
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$760	*1 per 60 months*
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$790	*1 per 60 months*
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$821	*1 per 60 months*
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$765	*1 per 60 months*
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$794	*1 per 60 months*
D6075	Implant supported retainer for ceramic FPD	$861	*1 per 60 months*
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$853	*1 per 60 months*
D6077	Implant supported retainer for metal FPD - high noble alloys	$835	*1 per 60 months*
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$97	*1 per 60 months*
D6081	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	$93	*1 per 60 months*

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$751	*1 per 60 months*
D6083	Implant supported crown - porcelain fused to noble alloys	$808	*1 per 60 months*
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$820	*1 per 60 months*
D6085	Provisional implant crown	$247	*1 per 60 months*
D6086	Implant supported crown - predominantly base alloys	$693	*1 per 60 months*
D6087	Implant supported crown - noble alloys	$745	*1 per 60 months*
D6088	Implant supported crown - titanium and titanium alloys	$820	*1 per 60 months*
D6090	Repair implant supported prosthesis, by report	$315	*1 per 60 months*
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$114	*1 per 60 months*
D6095	Repair implant abutment, by report	$322	*1 per 60 months*
D6096	Remove broken implant retaining screw	$160	*1 per 60 months*
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$820	*1 per 60 months*
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$760	*1 per 60 months*
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$790	*1 per 60 months*
D6100	Implant removal, by report	$463	*1 per 60 months*
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	$295	*1 per 60 months*
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	$413	*1 per 60 months*
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure	$519	
D6104	Bone graft at time of implant placement	$439	
D6110	Implant /abutment supported removable denture for edentulous arch - maxillary	$1,219	*1 per 60 months*
D6111	Implant /abutment supported removable denture for edentulous arch - mandibular	$1,219	*1 per 60 months*
D6112	Implant /abutment supported removable denture for partially edentulous arch - maxillary	$1,219	*1 per 60 months*
D6113	Implant /abutment supported removable denture for partially edentulous arch - mandibular	$1,219	*1 per 60 months*
D6114	Implant /abutment supported fixed denture for edentulous arch - maxillary	$1,857	*1 per 60 months*

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D6115	Implant /abutment supported fixed denture for edentulous arch - mandibular	$1,857	*1 per 60 months*
D6116	Implant /abutment supported fixed denture for partially edentulous arch - maxillary	$1,569	*1 per 60 months*
D6117	Implant /abutment supported fixed denture for partially edentulous arch - mandibular	$1,569	*1 per 60 months*
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$765	*1 per 60 months*
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$765	*1 per 60 months*
D6122	Implant supported retainer for metal FPD - noble alloys	$794	*1 per 60 months*
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$865	*1 per 60 months*
D6190	Radiographic/surgical implant index, by report	$349	*1 per 60 months*
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$853	*1 per 60 months*
D6200-D6999 IX. PROSTHODONTICS, fixed			
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).			
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 60+ months old.			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D6210	Pontic - cast high noble metal	$609	*1 per 60 months*
D6211	Pontic - cast predominantly base metal	$538	*1 per 60 months*
D6212	Pontic - cast noble metal	$570	*1 per 60 months*
D6214	Pontic - titanium and titanium alloys	$683	*1 per 60 months*
D6240	Pontic - porcelain fused to high noble metal	$656	*1 per 60 months*
D6241	Pontic - porcelain fused to predominantly base metal	$614	*1 per 60 months*
D6242	Pontic - porcelain fused to noble metal	$645	*1 per 60 months*
D6243	Pontic - porcelain fused to titanium and titanium alloys	$645	*1 per 60 months*
D6245	Pontic - porcelain/ceramic	$828	*1 per 60 months*
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$420	*1 per 60 months*
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$463	*1 per 60 months*
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$605	*1 per 60 months*
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$629	*1 per 60 months*
D6602	Retainer inlay - cast high noble metal, two surfaces	$550	*1 per 60 months*
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$572	*1 per 60 months*
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$517	*1 per 60 months*

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$533	*1 per 60 months*
D6606	Retainer inlay - cast noble metal, two surfaces	$534	*1 per 60 months*
D6607	Retainer inlay - cast noble metal, three or more surfaces	$543	*1 per 60 months*
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$671	*1 per 60 months*
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$745	*1 per 60 months*
D6610	Retainer onlay - cast high noble metal, two surfaces	$610	*1 per 60 months*
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$677	*1 per 60 months*
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$558	*1 per 60 months*
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$595	*1 per 60 months*
D6614	Retainer onlay - cast noble metal, two surfaces	$569	*1 per 60 months*
D6615	Retainer onlay - cast noble metal, three or more surfaces	$615	*1 per 60 months*
D6740	Retainer crown - porcelain/ceramic	$828	*1 per 60 months*
D6750	Retainer crown - porcelain fused to high noble metal	$753	*1 per 60 months*
D6751	Retainer crown - porcelain fused to predominantly base metal	$625	*1 per 60 months*
D6752	Retainer crown - porcelain fused to noble metal	$673	*1 per 60 months*
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	$753	*1 per 60 months*
D6780	Retainer crown - 3/4 cast high noble metal	$606	*1 per 60 months*
D6781	Retainer crown - 3/4 cast predominantly base metal	$567	*1 per 60 months*
D6782	Retainer crown - 3/4 cast noble metal	$588	*1 per 60 months*
D6783	Retainer crown - 3/4 porcelain/ceramic	$828	*1 per 60 months*
D6784	Retainer crown - 3/4 titanium and titanium alloys	$665	*1 per 60 months*
D6790	Retainer crown - full cast high noble metal	$665	*1 per 60 months*
D6791	Retainer crown - full cast predominantly base metal	$577	*1 per 60 months*
D6792	Retainer crown - full cast noble metal	$620	*1 per 60 months*
D6930	Re-cement or re-bond fixed partial denture	$80	
D6980	Fixed partial denture repair necessitated by restorative material failure	$299	
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY			
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$87	

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$150	
D7220	Removal of impacted tooth - soft tissue	$179	
D7230	Removal of impacted tooth - partially bony	$227	
D7240	Removal of impacted tooth - completely bony	$272	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$300	
D7250	Removal of residual tooth roots (cutting procedure)	$172	
D7251	Coronectomy - intentional partial tooth removal	$409	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$254	
D7280	Exposure of an unerupted tooth	$283	
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$167	
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$101	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$235	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$141	
D7471	Removal of lateral exostosis (maxilla or mandible)	$522	
D7510	Incision and drainage of abscess - intraoral soft tissue	$126	
D7910	Suture of recent small wounds up to 5 cm	$152	
D7921	Collection and application of autologous blood concentrate product	$420	*1 per 36 months*
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$12	
D7953	Bone replacement graft for ridge preservation - per site	$219	
D7971	Excision of pericoronal gingiva	$145	
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees (under age 19) ONLY			
- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when 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.			
- Pediatric Enrollee must continue to be eligible, benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.			
- 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 except for services provided by an orthodontist other than the original treating Contract Orthodontist or dental office.			
- Refer to Schedule B for Limitations and Exclusions for medically necessary orthodontics for additional information.			

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
- Cost Share for medically necessary orthodontics applies to course of treatment, not individual Benefit years within a multi-year course of treatment. This Cost Share applies to the course of treatment as long as the Pediatric Enrollee remains enrolled in the plan.			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$3,670	
D8090	Comprehensive orthodontic treatment of the adult dentition	$3,850	
D8660	Pre-orthodontic treatment examination to monitor growth and development	$50	*1 per 6 month period when performed by the same Contract Dentist or dental office*
D8670	Periodic orthodontic treatment visit	$270	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$536	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office who was paid for banding*
D8681	Removable orthodontic retainer adjustment	$49	
D8690	Orthodontic treatment (alternative billing to a contract fee)	$740	*Included in the orthodontic case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist; limited to transfer of care and removal of appliances.*
D8698	Re-cement or re-bond fixed retainer - maxillary	$109	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*
D8699	Re-cement or re-bond fixed retainer - mandibular	$109	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*
D8701	Repair of fixed retainer, includes reattachment - maxillary	$109	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D8702	Repair of fixed retainer, includes reattachment - mandibular	$109	*Included in comprehensive case fee; a separate fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES			
- Cost Share for Benefits in this category is subject to the Plan Deductible described in your <EOC NAME>. You pay the Charges shown below until you have met the Plan Deductible. After you meet the Plan Deductible, the Services are covered at no charge for the remainder of the year.			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$63	
D9222	Deep sedation/general anesthesia - first 15 minutes	$94	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$94	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$91	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$91	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$72	
D9311	Consultation with a medical health care professional	$43	
D9610	Therapeutic parenteral drug, single administration	$33	
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$73	
D9932	Cleaning and inspection of removable complete denture, maxillary	$40	
D9933	Cleaning and inspection of removable complete denture, mandibular	$33	
D9934	Cleaning and inspection of removable partial denture, maxillary	$81	
D9935	Cleaning and inspection of removable partial denture, mandibular	$60	
D9943	Occlusal guard adjustment	$168	*1 per 12 months (6 months after initial placement)*
D9944	Occlusal guard - hard appliance, full arch	$313	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*

Code	Description	Pediatric Enrollee Cost Share	Clarification/Limitations for Pediatric Enrollees
D9945	Occlusal guard - soft appliance, full arch	$78	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*
D9946	Occlusal guard - hard appliance, partial arch	$156	*1 of (D9944, D9945, D9946) per 12 months; age 13 and up*
D9986	Missed appointment	$26	*Without 24 hour notice*
D9987	Cancelled appointment	$50	*Without 24 hour notice*
D9995	Teledentistry - synchronous; real-time encounter	$20	
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	$20	

a. Endnotes:

i. Unless clarified elsewhere in the Schedule A, base metal is the Benefit. If noble or high noble metal (precious) is used for an implant/abutment supported crown or fixed bridge retainer, the Enrollee will be charged the additional laboratory cost of the noble or high noble metal. If covered, an additional laboratory charge also applies to a titanium crown.

ii. Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of $150 per unit.

iii. When there are more than six crowns, retainers and/or pontics in the same treatment plan, an Enrollee may be charged an additional $125 per unit, beyond the 6th unit.

iv. Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325 in addition to the listed Copayment. Refer to Schedule B for Limitations and Exclusions for additional information.

v. If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment(s). Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment(s) specified for such services.

vi. Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the Contract Dentist and formally agreed upon by financial consent that satisfies the same dental need as a covered procedure. Enrollee may elect an optional or upgraded procedure, subject to the Limitations and Exclusions of this Plan. The applicable charge to the Enrollee is the difference between the Contract Dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable copayment for the covered procedure.

18.9 **SCHEDULE B**

a. **Limitations and Exclusions of Benefits for Pediatric Enrollees (Under age 19)**

i. **Limitations of Benefits for Pediatric Enrollees**

1) The frequency of certain Benefits is limited. Frequency Limitations are listed in Schedule A, Description of Benefits and Cost Share.

2) Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

3) Additional coverage of Panoramic and cephalometric x-rays (D0330, D0340) is allowed as part of an initial medically necessary orthodontic treatment or on an emergency basis.

4) Sealants (D1351, D1352) are covered only on permanent molars. The teeth must be caries free with no restorations on the mesial, distal or occlusal surfaces.

5) Repair or replacement of restorations by the same dentist and involving the same tooth surfaces, performed within 24 months of the original restoration are included, and a separate fee is not chargeable to the Enrollee by a Contract Dentist. However,

coverage may be allowed if the repair or replacement is due to fracture of the tooth or the restoration involves the occlusal surface of a posterior tooth or the lingual surface of an anterior tooth and is placed following root canal therapy.

6) Covered restorations includes all related services, such as etching, bases, liners, dentinal adhesives, local anesthesia, polishing, caries removal, preparation of gingival tissue, occlusal/contact adjustments, and detection agents.
7) Resin restoration is a Benefit when a laboratory fabricated porcelain or resin veneer is used to restore any teeth due to tooth fracture or caries.
8) Prefabricated crowns are covered only on primary teeth, permanent teeth through age 14, or when placed as a result of accidental injury.
9) Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. Contract Dentists may offer services that utilize brand or trade names at an additional fee. The Enrollee must be offered the plan Benefits of a high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If the Enrollee chooses the alternative of a material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials) the Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Examples of material upgrade include: Captek, Procera, Lava, Empress and Cerec. Contact the Customer Service department at 888-857-0337 if you have questions regarding the additional fee or name brand services.
10) Onlays, permanent single crown restorations, and posts and cores for Enrollees 12 years of age or younger are excluded from coverage, unless specific rationale is provided indicating the reason for such treatment (e.g., fracture, endodontic therapy, etc.) and is approved by the plan.
11) Core buildups (D2950) can be considered for Benefits only when there is insufficient retention for a crown. A buildup should not be reported when the procedure only involves a filler used to eliminate undercuts, box forms or concave irregularities in the preparation.
12) Replacement of crowns, inlays, onlays, buildups, and posts and cores is covered only if the existing crown, inlay, onlay, buildup, or post and core was inserted at least sixty (60) months prior to the replacement and satisfactory evidence is presented that the existing crown, inlay, onlay, buildup, or post and core is not and cannot be made serviceable. The sixty (60) month service date is measured based on the actual date (day and month) of the initial service versus the first day of the initial service month.
13) Onlays, crowns, and posts and cores are covered only when necessary due to decay or tooth fracture. However, if the tooth can be adequately restored with amalgam or composite (resin) filling material, coverage is for that service. Crowns, inlays, onlays, buildups, or posts and cores, begun prior to the effective date of coverage or cemented after the cancellation date of coverage, are not eligible for coverage.
14) Recement or re-bond of prefabricated and cast crowns, bridges, onlays, inlays, and posts is provided within 12 months of placement by the same dentist is included at no additional cost to the Enrollee.
15) Posts are only covered when provided as part of a buildup for a crown. When performed as an independent procedure, the placement of a post is not a covered Benefit.
16) Pulpotomies are included when performed by the same dentist within a 45-day period prior to the completion of root canal therapy.
    a) A pulpotomy is covered when performed as a final endodontic procedure and is covered generally on primary teeth only. Pulpotomies performed on permanent teeth are included to root canal therapy and are not reimbursable unless specific

rationale is provided and root canal therapy is not and will not be provided on the same tooth.

b) Pulpotomies performed on permanent teeth are included to root canal therapy and are not reimbursable unless specific rationale is provided and root canal therapy is not and will not be provided on the same tooth.

17) Incomplete endodontic therapy is not a covered Benefit when due to the Enrollee discontinuing treatment.

18) For reporting and Benefit purposes, the completion date for endodontic therapy is the date the tooth is sealed.

19) Subepithelial connective tissue grafts and combined connective tissue and double pedicle grafts are covered at the level of free soft tissue grafts.

20) A single site for reporting osseous grafts consists of one contiguous area, regardless of the number of teeth (e.g., crater) or surfaces involved. Another site on the same tooth is included to the first site reported. Non-contiguous areas involving different teeth may be reported as additional sites.

21) Up to four periodontal maintenance procedures and up to two routine prophylaxes may be covered within a 12 consecutive month period, but the total of periodontal maintenance and routine prophylaxes may not exceed four procedures in a 12-month period.

a) Periodontal maintenance is only covered when performed following active periodontal treatment.

b) An oral evaluation reported in addition to periodontal maintenance will be covered as a separate procedure subject to the policy and Limitations applicable to oral evaluations.

22) Coverage for multiple periodontal surgical procedures (except soft tissue grafts and osseous grafts) provided in the same area of the mouth during the same course of treatment is based on the fee for the greater surgical procedure.

23) Charges for related services such as necessary wires and splints, adjustments, and follow up visits are included to the fee for reimplantation and/or stabilization.

24) Routine post-operative care such as suture removal is included to the fee for the surgery.

25) The removal of impacted teeth is covered based on the anatomical position as determined from a review of x-rays. If the degree of impaction is determined to be less than the reported degree, coverage will be based on the allowance for the lesser level.

26) Removal of impacted third molars in Enrollees under age 15 is not covered unless specific documentation is provided that substantiates the need for removal and is approved by the plan.

27) For reporting and Benefit purposes, the completion date for crowns and fixed partial dentures is the cementation date. The completion date is the insertion date for removable prosthodontic appliances. For immediate dentures, however, the dentist who fabricated the dentures may be reimbursed for the dentures after insertion if another dentist, typically an oral surgeon, inserted the dentures.

28) Removable cast base partial dentures for Enrollees under 12 years of age are excluded from coverage unless specific rationale is provided indicating the necessity for that treatment and is approved by the plan.

29) Re-cement or re-bond of prefabricated and cast crowns, bridges, onlays, inlays, and posts is eligible once per 6-month period. Recement or re-bond provided within 12 months of placement by the same dentist is included at no additional cost to the Enrollee. Adjustments provided within six months of the insertion of an initial or replacement denture or implant are included at no additional cost to the Enrollee when made by the same dentist.

30) With the exception of a new immediate denture, relining or rebasing is covered at no additional cost to the Enrollee within six months of a denture's initial delivery.

31) Coverage for a denture made with precious metals is based on the allowance for a conventional denture.

32) A removable partial denture to replace all missing teeth in the arch is the Benefit.

33) Precision attachments, personalization, precious metal bases, and other specialized techniques are not covered Benefits.

34) Replacement of removable prostheses and fixed prostheses is covered only if the existing removable and/or fixed prostheses was inserted at least sixty (60) months prior to the replacement and satisfactory evidence is presented that the existing removable and/or fixed prostheses cannot be made serviceable. Satisfactory evidence must show that the existing removable prostheses and/or fixed prostheses cannot be made serviceable. The 60-month service date is measured based on the actual date (day and month) of the initial service versus the first day of the initial service month.

35) Implants and related prosthetics may be covered and may be reimbursed as an alternative Benefit as a three unit fixed partial denture (FPD).

36) Replacement of appliances that have been lost, stolen, or misplaced is not a covered service. Examples include: full or partial dentures, space maintainers, crowns and prostheses.

37) Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) only when provided in connection with a covered procedure(s) and when rendered by a dentist or other professional licensed dentist and approved to provide anesthesia in the state where the service is rendered.

38) Deep sedation/general anesthesia and intravenous conscious sedation are covered (by report) when determined to be medically or dentally necessary for documented handicapped or uncontrollable Enrollees or justifiable medical or dental conditions.

39) In order for deep sedation/general anesthesia and intravenous conscious sedation to be covered, the procedure for which it was provided must be submitted. Services submitted without a report will be denied as a non-covered Benefit.

40) For palliative (emergency) treatment to be covered; it must involve a problem or symptom that occurred suddenly and unexpectedly that requires immediate attention. The dentist must provide treatment to alleviate the Enrollee's problem. If the only service provided is to evaluate the Enrollee and refer to another dentist and/or prescribe medication, it would be considered a limited oral evaluation - problem focused.

41) Consultations are covered only when provided by a dentist other than the practitioner providing the treatment.

42) After hours' visits are covered only when the dentist must return to the office after regularly scheduled hours to treat the Enrollee in an emergency situation.

43) Therapeutic drug injections are only covered in unusual circumstances, which must be documented by report. They are not Benefits if performed routinely or in conjunction with, or for the purposes of, general anesthesia, analgesia, sedation or premedication.

44) Occlusal guards are covered by report for Enrollee 13 years of age or older when the purpose of the occlusal guard is the treatment of bruxism and shall be prior authorized.

ii. **Exclusions of Benefits for Pediatric Enrollees.** Except as specifically provided, the following services, supplies, or charges are not covered:

1) Any dental service or treatment not specifically listed under Schedule A, Description of Benefits and Cost Share, as a covered service.

2) Dental services received from any dental facility other than the assigned Contract Dentist or an authorized Contract Specialist (oral surgeon, endodontist, periodontist, pediatric dentist or Contract Orthodontist) except for Emergency Services as described in the Contract.

3) Those not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, the plan will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law.
4) Any procedure that has a poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or is inconsistent with meeting accepted standards of dental practice.
5) Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
6) Those incurred after the termination date of the member's coverage unless otherwise indicated.
7) Those which are not medically or dentally necessary, or which are not recommended or approved by the treating dentist. (Services determined to be unnecessary or which do not meet accepted standards of dental practice are not billable to the Enrollee by a Contract Dentist unless the dentist notifies the Enrollee of his/her liability prior to treatment and the Enrollee chooses to receive the treatment. Contract Dentists should document such notification in their records.)
8) Services or treatment provided by a member of the Enrollee's immediate family.
9) Those services submitted by a dentist which are for the same services performed on the same date for the same Enrollee by another dentist.
10) Those which are experimental or investigative (deemed unproven).
11) Those which are for unusual procedures and techniques and may not be considered generally accepted practices by the American Dental Association.
12) Consultations or other diagnostic services for non-covered Benefits.
13) Telephone consultations.
14) All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
15) Prescription and over-the-counter drugs.
16) Preparations that can be used at home, such as fluoride gels, special mouth rinses (including antimicrobials), etc.
17) Those which are for any illness or bodily injury which occurs in the course of employment if Benefits or compensation is available, in whole or in part, under the provision of any legislation of any governmental unit. This Exclusion applies whether or not the member claims the Benefits or compensation.
18) Those which are later recovered in a lawsuit or in a compromise or settlement of any claim, except where prohibited by law.
19) Those provided free of charge by any governmental unit, except where this Exclusion is prohibited by law.
20) Those for which the member would have no obligation to pay in the absence of this or any similar coverage.
21) Those received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.
22) Services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary orthodontics provided prior Authorization is obtained.
23) Those performed by a dentist who is compensated by a facility for similar covered services performed for members.

24) Those resulting from the Enrollee's failure to comply with professionally prescribed treatment.
25) Any charges for failure to keep a scheduled appointment.
26) Duplicate and temporary devices, appliances, and services.
27) Any services that are considered strictly cosmetic in nature such as charges for personalization or characterization of prosthetic appliances.
28) Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD).
29) Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
30) Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is covered under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
31) Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization.
32) Services or treatment provided as a result of intentionally self-inflicted injury or illness.
33) Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection.
34) Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
35) Charges for copies of Enrollees' records, charts or x-rays, or any costs associated with forwarding/mailing copies of Enrollees' records, charts or x-rays.
36) State or territorial taxes on dental services performed.
37) Adjunctive dental services as defined by applicable federal regulations. These are medical services that may be covered under a medical policy even when provided by a general dentist or oral surgeon.
    a) Adjunctive dental care is dental care that is:
        i) Medically necessary in the treatment of an otherwise covered medical (not dental) condition.
        ii) An integral part of the treatment of such medical condition.
        iii) Essential to the control of the primary medical condition.
        iv) Required in preparation for or as the result of dental trauma, which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic).
    b) The following diagnoses or conditions may fall under this category:
        i) Treatment for relief of Myofascial Pain Dysfunction Syndrome (MFPS) or Temporomandibular Joint Dysfunction (TMJD).
        ii) Orthodontic treatment for cleft palate, or when required in preparation for, or as a result of, trauma to teeth and supporting structures caused by medically necessary treatment of an injury or disease.
        iii) Procedures associated with preventive and restorative dental care when associated with radiation therapy to the head or neck unless otherwise covered as a routine preventive procedure under this plan.
        iv) Treatment of total or complete ankyloglossia.
        v) Treatment of an extraoral abscess or intraoral abscess that extends beyond the dental alveolus.
        vi) Treatment of cellulitis and osteitis, which is clearly exacerbating and directly affecting a medical condition currently under treatment.

vii) Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.

viii) Prosthetic replacement of either the maxilla or mandible due to reduction of body tissues associated with traumatic injury (such as a gunshot wound) in addition to services related to treating neoplasms or iatrogenic dental trauma.)

38) Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.

39) The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered Benefit.

b. **Policies, Limitations, and Exclusions for Medically Necessary Orthodontic Services for Pediatric Enrollees**

i. Services are limited to medically necessary orthodontics when provided by a Contract Dentist and when necessary and customary under generally accepted dental practice standards. Orthodontic treatment is a Benefit of this plan only when medically necessary as evidenced by a severe handicapping malocclusion for Pediatric Enrollees and shall be prior authorized by the plan.

ii. 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.

iii. The automatic qualifying conditions are:

1) 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,

a) A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,

b) A crossbite of individual anterior teeth causing destruction of soft tissue,

c) Severe traumatic deviation.

2) The following documentation must be submitted to the plan with the request for prior authorization of services by the Contract Dentist:

a) ADA 2006 or newer claim form with service code(s) requested;

b) Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;

c) Cephalometric radiographic image or panoramic radiographic image;

d) HLD score sheet completed and signed by the Orthodontist; and

e) Treatment plan.

iv. 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.

v. Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original treating orthodontist.

vi. Orthodontic procedures are Benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Pediatric Enrollees and shall be prior authorized.

vii. 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.

viii. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

ix. When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, the plan will make an allowance for the cost of a standard orthodontic treatment.

x. Repair and replacement of an orthodontic appliance inserted under the plan that has been damaged, lost, stolen, or misplaced is not a covered service.

xi. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

1) If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, the plan will continue to provide orthodontic Benefits for:

   a) For 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or

   b) Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

2) At the end of 60 days (or at the end of the Quarter), the Enrollee's obligation shall be based on the Contract Orthodontist's submitted fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.