

1  
2  
3 **RESOLUTION NO. 2018-13**  
4

5 **A RESOLUTION OF THE VILLAGE**  
6 **COMMISSION OF THE VILLAGE OF**  
7 **BISCAYNE PARK, FLORIDA APPROVING**  
8 **THE SELECTION OF AVMED AS THE**  
9 **VILLAGE'S HEALTH PLAN PROVIDER;**  
10 **PROVIDING FOR AN EFFECTIVE DATE**  
11

12  
13  
14 WHEREAS, the Village of Biscayne Park's current health plan contract is due to expire  
15 on May 31, 2018; and  
16

17  
18 WHEREAS, Village administration has compared the renewal rates and benefits  
19 provided by the current health plan company along with other major carriers; and  
20

21  
22 WHEREAS, the Village administration found that the AvMed health plan proposal  
23 would improve benefits for plan participants; and  
24

25  
26 WHEREAS, the Village Commission finds it to be in the best interests of the Village to  
27 approve the selection of AvMed as the Village's health plan provider;  
28

29  
30 NOW THEREFORE BE IT RESOLVED BY THE VILLAGE COMMISSION OF THE  
31 VILLAGE OF BISCAYNE PARK, FLORIDA:  
32

33  
34 **Section 1.** The foregoing "Whereas" clauses are hereby ratified and confirmed as  
35 being true and correct and hereby made a specific part of this Resolution upon adoption hereof.  
36

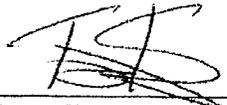
37 **Section 2.** The selection of AvMed as the Village's health plan provider is hereby  
38 approved.  
39

40 **Section 3.** This Resolution shall become effective upon adoption.  
41

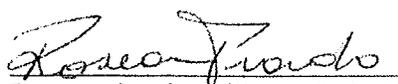
42  
43 PASSED AND ADOPTED this 1<sup>st</sup> day of May, 2017.  
44

45  
46 The foregoing resolution upon being  
47 put to a vote, the vote was as follows:

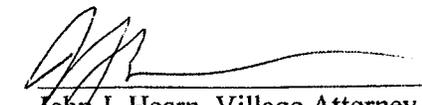
Mayor Truppman: Yes  
Vice Mayor Tudor: Yes  
Commissioner Bilt: Yes  
Commissioner Johnson-Sardella: Yes  
Commissioner Ross: Yes

1  
2  
3  
4   
5 \_\_\_\_\_  
6 Tracy Truppman, Mayor  
7

8  
9 Attest:

10  
11   
12 \_\_\_\_\_  
13 Roseann Prado, Village Clerk  
14

15  
16 Approved as to form:

17  
18   
19 \_\_\_\_\_  
20 John J. Hearn, Village Attorney  
21

**GROUP CONFIRMATION**

May 13, 2018

Village of Biscayne Park  
Attn: Marlen Martell  
640 NE 114th Street  
Biscayne Park, FL 33161

**Subscribing Group:** Village of Biscayne Park  
**Effective Date:** 06/01/2018  
**Group Number:** 127576

Dear AvMed Client:

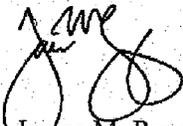
Thank you for selecting AvMed for your healthcare needs. Please accept this as a confirmation of your group benefit plan. As of the effective date, the above-named Subscribing Group has selected the following plan:

<u>Benefit Plan</u>	<u>Identifier</u>	<u>Description</u>
Achieve LG200-SG18	AVSG_HG_1087_0118	Summary of Benefits & Coverage

Enclosed you will find your AvMed Group Medical & Hospital Service Contract, and applicable Benefit Summaries, Amendments, application, and rates. The provisions contained in the Summary of Benefits & Coverage and all exhibits and Amendments attached hereto are, by reference, a part of this Contract.

Should you have questions regarding your benefits, please contact our **Member Engagement Department at 1-800-376-6651**. If you have questions about your group policy, please feel free to contact the Small Group Support Center at 1-800-835-6131 or e-mail your Small Group Representative,

Best Regards,



James M. Repp  
President and COO

CC:

Maureen Pentland  
EBS Advisors, Inc  
(954)651-6060

## ERISA SUMMARY PLAN DESCRIPTION INFORMATION

**Official Plan Name:** Village of Biscayne Park

**Plan Sponsor:** Village of Biscayne Park  
640 NE 114th Street  
Biscayne Park, FL 33161  
(305)899-8000

**Plan Administrator:** Village of Biscayne Park  
640 NE 114th Street  
Biscayne Park, FL 33161  
(305)899-8000

**Claims Administrator:** AvMed Inc.  
d/b/a AvMed Health Plans  
9400 S Dadeland Blvd.  
Miami, FL 33156

**Plan Year:** 2018

**Effective Date of Plan:** 06/01/2018

**Employer Identification Number:** 596000277

**Plan Type:** **Fully-Insured Welfare Benefit Plan: Small Group Achieve**

**Source of Funding for Plan:** Benefits under the plan are provided through a fully-insured contract with AvMed Health Plans.

**Source of Contribution:** Employer and Employee contributions. The amount of the contributions are determined by Plan Administrator.

**ERISA Plan No.:** Not Available

**Agent for Service of Legal Process:** Steven M. Ziegler  
4300 NW 89th Blvd  
Gainesville, FL 32606

**Organization that Provides the Benefit:** AvMed Inc.  
d/b/a AvMed Health Plans  
9400 S Dadeland Blvd.  
Miami, FL 33156

**Are you required to file form 5500:** No

**Do you work with an agent/broker:** Yes



**Small Group Achieve Plan  
Medical and Hospital Service Contract**

James M. Repp  
President & COO

A handwritten signature in black ink, appearing to read "James M. Repp", written in a cursive style.

**TABLE OF CONTENTS**

**SERVICE AREAS ..... ii**

**I. INTRODUCTION ..... 1**

**II. DEFINITIONS ..... 2**

**III. ELIGIBILITY FOR COVERAGE ..... 11**

**IV. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE ..... 12**

**V. TERMINATION ..... 14**

**VI. MONTHLY PREMIUM PAYMENTS, COPAYMENTS, COINSURANCE AND DEDUCTIBLES ..... 20**

**VII. PHYSICIANS, HOSPITALS AND OTHER PROVIDER OPTIONS ..... 21**

**VIII. COVERED BENEFITS AND SERVICES ..... 22**

**IX. COVERED SERVICE CATEGORIES ..... 25**

**X. LIMITATIONS OF COVERED SERVICES ..... 37**

**XI. EXCLUSIONS FROM COVERED SERVICES ..... 38**

**XII. PHARMACY MEDICATION BENEFITS ..... 44**

**XIII. REVIEW PROCEDURES/HOW TO APPEAL A CLAIM (BENEFIT DENIAL) ..... 46**

**XIV. COORDINATION OF BENEFITS ..... 51**

**XV. SUBROGATION AND RIGHT OF RECOVERY ..... 53**

**XVI. DISCLAIMER OF LIABILITY AND RELATIONSHIPS BETWEEN THE PARTIES ..... 54**

**XVII. GENERAL PROVISIONS ..... 55**

**XVIII. PEDIATRIC DENTAL BENEFITS ..... 58**

**AVMED CORPORATE OFFICE  
9400 S. DADELAND BLVD.  
MIAMI, FL 33156-9004**

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

**SERVICE AREAS**

**MIAMI**

9400 South Dadeland Boulevard  
Miami, Florida 33156-9004  
(305) 671-5437  
(800) 432-6676  
Miami-Dade

**FT. LAUDERDALE**

13450 West Sunrise Boulevard  
Suite 370  
Sunrise, Florida 33323-2947  
(954) 462-2520  
(800) 368-9189  
Broward  
Martin  
Palm Beach  
St. Lucie

**ORLANDO**

1800 Pembroke Drive  
Suite 190  
Orlando, Florida 32810  
(407) 539-0007  
(800) 227-4848  
Lake  
Orange  
Osceola  
Seminole  
Volusia

**GAINESVILLE**

4300 Northwest 89<sup>th</sup> Boulevard  
Post Office Box 749  
Gainesville, Florida 32627-0749  
(352) 372-8400  
(800) 346-0231

Alachua  
Bradford  
Citrus  
Columbia  
Dixie  
Gilchrist  
Hamilton  
Levy  
Marion  
Suwannee  
Union

**JACKSONVILLE**

1300 Riverplace Boulevard  
Suite 640  
Jacksonville, Florida 32207  
(904) 858-1300  
(800) 227-4184

Baker  
Clay  
Duval  
Nassau  
St. Johns

**TAMPA BAY/ SOUTHWEST  
FLORIDA**

1511 North Westshore Boulevard  
Suite 450  
Tampa, Florida 33607  
(813) 281-5650  
(800) 257-2273  
Hernando  
Hillsborough  
Lee  
Manatee  
Pasco  
Pinellas  
Polk  
Sarasota

**AvMed, Inc.**  
**SMALL GROUP ACHIEVE PLAN**  
**MEDICAL AND HOSPITAL SERVICE CONTRACT**

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

**I. INTRODUCTION**

- 1.1 **Provision of Health Care Services and Benefits.** The Subscribing Group engages AvMed, on behalf of the group health plan described herein (the "Plan"), to arrange for the provision of Health Care Services or benefits which are Medically Necessary for the diagnosis and treatment of Members of the Subscribing Group. AvMed arranges for the delivery of Health Care Services or benefits, in accordance with the covenants and conditions contained in this Contract, and does not directly provide these Health Care Services or benefits. AvMed shall rely upon the statements of the Subscriber in his Application in providing coverage and benefits hereunder.
- 1.2 **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 shall be guided by the direct service nature of AvMed's program and the definitions and other provisions contained herein.
- 1.3 **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 sections contained in this Contract are for reference purposes only and will not affect in any way the meaning or interpretation of particular provisions.
- 1.4 **Guaranteed Renewability of Contract.** This Contract is guaranteed renewable and will stay in effect as long as you remain eligible for coverage and Premiums are paid on time. You 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.
- 1.5 **References in this Contract.**
  - a. References to 'you' or 'your' throughout refer to you as the Subscriber and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references which refer solely to you as the Subscriber or solely to your Covered Dependents will be noted as such.
  - b. References to 'we', 'us' and 'our' throughout refer to AvMed.
  - c. Whenever used, the singular shall include the plural, and the plural the singular, and the use of any gender shall include all genders.
  - d. References to the 'Plan' refer to this AvMed Small Group Achieve Plan.
  - 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 the 'Definitions' Section or defined within the particular Section where it is used.
- 1.6 **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 shall have the meaning indicated:

- 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 natural teeth caused by biting or chewing, surgery or treatment for a disease or illness.
- 2.2 **Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to arrange or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to arrange or make payment that is based on a determination of a Member's eligibility to participate in the Plan, and including 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.
- 2.3 **Allowed Amount** means the maximum amount upon which payment will be based for Covered Services rendered by Participating Providers. The Allowed Amount may be changed at any time without notice to you or your consent.
- 2.4 **Ambulatory Surgery Center** means a facility licensed pursuant to Chapter 395, *Florida Statutes*, the primary purpose of which is to provide surgical care to a patient admitted to, and discharged from, such facility within the same working day.
- 2.5 **Attending Physician** means the Participating Physician primarily responsible for the care of a Member with respect to any particular injury or illness.
- 2.6 **Breast Reconstructive Surgery** means surgery to re-establish symmetry between the two breasts following breast cancer treatment.
- 2.7 **Calendar Year** begins January 1<sup>st</sup> and ends December 31<sup>st</sup>.
- 2.8 **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. The Calendar Year Deductible may not apply to all services. For more information please see Part VI. MONTHLY PREMIUM PAYMENTS, COPAYMENTS, COINSURANCE AND DEDUCTIBLES.
- 2.9 **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. This limit never includes your Premiums, Prescription Drug brand additional charges, or charges for health care that AvMed does not cover.
- 2.10 **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 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** is 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. 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, shall constitute an Adverse Benefit Determination.

- d. Post-Service Claim means any Claim for benefits under this Contract that is not a Pre-Service Claim.
- 2.11 **Claimant** means a Member or a Member's authorized representative acting on behalf of a Member.
- 2.12 **Coinsurance** means the amount a Member must pay once any applicable Deductible has been met, and is expressed as a percentage of the Allowed Amount for the Covered Benefit, or the percentage of an amount based on the Maximum Medicare Allowable or Average Wholesale Price for the Covered Benefit. For more information please see Part VI. MONTHLY PREMIUM PAYMENTS, COPAYMENTS, COINSURANCE AND DEDUCTIBLES.
- 2.13 **Condition** means a disease, illness, ailment, injury, or pregnancy.
- 2.14 **Contract** means this AvMed Small Group Achieve Plan Medical and Hospital Service Contract which may at times be referred to as "**Group Contract**" or "**Subscribing Group Contract**" and all applications, Rate Letters (as described in Section 17.25), schedules, amendments, and any other document approved by the Florida Office of Insurance Regulation for incorporation into this Contract from time to time.
- 2.15 **Copayment** means the fixed dollar amount established solely by AvMed which you are required to pay to a Health Care Provider usually at the time Covered Services are rendered by that provider. For more information please see Part VI. MONTHLY PREMIUM PAYMENTS, COPAYMENTS, COINSURANCE AND DEDUCTIBLES.
- 2.16 **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.
- 2.17 **Covered Benefits** or **Covered Services** means those Health Care Services to which a Member is entitled under the terms of this Contract.
- 2.18 **Covered Dependent** means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered under this Contract other than as a Subscriber (see Section 3.2).
- 2.19 **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.
- 2.20 **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. Dental Care is covered only for children through the end of the Calendar Year in which they turn 19, except as described in Section 9.11. For more information about covered pediatric dental benefits please see Part XVIII. PEDIATRIC DENTAL BENEFITS.
- 2.21 **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.

- 2.22 **Domestic Partner** means an unmarried adult who:
- a. cohabits with you in an emotionally committed and affectional relationship that is meant to be of lasting duration;
  - b. is not related by blood or marriage;
  - c. is at least 18 years of age;
  - d. is mentally competent to consent to a contract;
  - e. has filed a domestic partnership agreement or registration with the Subscribing Group, if available, in the state (and/or city) of residence;
  - f. has shared financial obligations including basic living expenses for the twelve-month period prior to enrollment in the Plan;
  - g. provides documentation satisfactory to AvMed as evidence of a Domestic Partner relationship; and
  - h. meets the dependent eligibility requirements of this Plan.
- 2.23 **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 home.
- 2.24 **Effective Date** means, with respect to Eligible Employees and Eligible Dependents properly enrolled, when coverage first becomes effective, at 12:00 a.m. (midnight) on the date so specified in your Plan materials. With respect to eligible individuals who are subsequently enrolled, it means 12:00 a.m. (midnight) on the date coverage will commence as specified in Part IV. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE.
- 2.25 **Eligible Dependent.** Eligible Dependent means a Subscriber's spouse or Domestic Partner, and children, who meet and continue to meet the eligibility requirements, as described in Part III. ELIGIBILITY FOR COVERAGE.
- 2.26 **Eligible Employee** means an employee of the Subscribing Group who meets and continues to meet the eligibility requirements described in Part III. ELIGIBILITY FOR COVERAGE and the Master Application. Eligible Employees must work or reside in the Achieve Plan Service Area.
- 2.27 **Emergency Medical Condition.**
- a. Emergency Medical Condition means 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;
    - 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.
- 2.28 **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 illness or care that can reasonably be sought and obtained from the Member's Participating Physician. The determination as to whether or not an illness or injury constitutes an Emergency Medical Condition shall be made by AvMed and may be made retrospectively based upon all information known at the time the patient 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 shall be made by AvMed and may be made retrospectively based upon all information known at the time the patient was present for treatment.

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

2.30 **Experimental or Investigational** means:

- a. any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined by AvMed:
  - i. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the 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;
  - vii. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
  - viii. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.
- 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.
- c. In determining whether a Health Care Service is Experimental or Investigational, we may also rely on the predominant opinion among experts, as expressed in the published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

- 2.31 **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. For more information see Part XII. PHARMACY MEDICATION BENEFITS.
- 2.32 **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.
- 2.33 **Habilitation Services** are services 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. For more information, please see Section 9.21.
- 2.34 **Health Care Providers** means Health Professionals and also 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.
- 2.35 **Health Care Services** (except as limited or excluded by this Contract) means the professional services of Physicians and other 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.
- 2.36 **Health Professionals** means allopathic and osteopathic Physicians, podiatrists, chiropractors, physician assistants, nurses, licensed clinical social workers, pharmacists, optometrists, nutritionists, occupational therapists, physical therapists, certified nurse midwives and midwives, and other professionals engaged in the delivery of Health Care Services, who are appropriately licensed under applicable state law.

- 2.37 **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.
- 2.38 **Hospice** means a public agency or private organization which is 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.
- 2.39 **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. 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.
- a. 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.
- 2.40 **Hospital-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-affiliated facility. See also Section 2.42 below.
- 2.41 **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.
- 2.42 **Independent Facility** means a facility not under common ownership, licensure or control of a Hospital, and sometimes referred to as a non-Hospital-affiliated facility. The cost-sharing for some services may vary depending on whether or not they are obtained at an Independent Facility.
- 2.43 **Injectable Medication** means a medication that has been approved by the United States 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. Prior Authorization may be required for Injectable Medications.
- 2.44 **Limitation** means any provision other than an Exclusion that restricts coverage under this Contract.
- 2.45 **Master Application** means the Subscribing Group application form entitled 'Master Application' which becomes a part of the Contract when the Master Application has been completed and executed by the Subscribing Group and AvMed.
- 2.46 **Material Misrepresentation** means the omission, concealment of facts or incorrect statements made on any application or enrollment forms by an applicant, Subscriber or Covered Dependent which, had they been known, would have affected our decision to issue this Contract, the issuance of different benefits, or the issuance of this Contract only at a higher rate.
- 2.47 **Maximum Allowable Payment** means the maximum amount that AvMed will pay for any Covered Service rendered by a Non-Participating Provider or supplier of services, medications or supplies, except for Emergency Medical Services and Care as described in Section 9.20.
- 2.48 **Medical Office** means any outpatient facility or Physician's office in the AvMed Achieve Plan Service Area utilized by a participating Health Professional.

- 2.49 **Medically Necessary or Medical Necessity.**
- a. Medically Necessary or Medical Necessity means the use of any appropriate medical treatment, service, equipment or supply as provided by a Hospital, Skilled Nursing Facility, Physician or other provider which is necessary, as determined by AvMed, for the diagnosis, care or treatment of a Member's illness or injury and which is:
    - i. consistent with the symptoms, diagnosis, and treatment of the Member's Condition;
    - ii. the most appropriate level of supply or service for the diagnosis and treatment of the Member's Condition;
    - iii. in accordance with standards of acceptable community practice;
    - iv. not primarily intended for the personal comfort or convenience of the Member, the Member's family, the Physician or other Health Professional;
    - v. 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
    - vi. not Experimental or Investigational.
- 2.50 **Medicare** means the federal health insurance provided pursuant to Title XVIII of the Social Security Act and all amendments thereto.
- 2.51 **Member** means any person who meets all applicable requirements of Part III. ELIGIBILITY FOR COVERAGE and enrolls in the Plan as a Subscriber or Covered Dependent, and for whom the Premium prepayment required by Part VI. MONTHLY PREMIUM PAYMENTS, COPAYMENTS, COINSURANCE AND DEDUCTIBLES, has actually been received by AvMed.
- 2.52 **Non-Participating Provider or Out-of-Network Provider** means any Health Care Provider with whom AvMed has neither contracted nor made arrangements to render the professional Health Care Services set forth herein as a Participating Provider.
- 2.53 **Other Health Care Facility(ies)** means any licensed facility, other than acute care Hospitals and those facilities providing services to Ventilator Dependent Care patients, which provides inpatient services at an intermediate or lower level of care such as skilled nursing care, Residential Treatment, and Rehabilitation Services.
- 2.54 **Outpatient Rehabilitation Facility** means an entity which renders, through Health Professionals licensed pursuant to Florida law: outpatient physical, occupational, speech, and cardiac rehabilitation therapies for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition, and with which AvMed has contracted or made arrangements for the provision of such services. The term Outpatient Rehabilitation Facility, as used herein, shall not include any Hospital, including a general acute care Hospital, or any separately organized unit of a Hospital which provides comprehensive medical rehabilitation inpatient services, or rehabilitation outpatient services, including a Class III or Class IV "specialty rehabilitation hospital" as described in Chapter 59A, *Florida Administrative Code*.
- 2.55 **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.
- 2.56 **Partial Hospitalization** means treatment in which an individual receives at least seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a 'home' for purposes of this definition.
- 2.57 **Participating Physician or Participating Provider** means any Health Care Provider with whom AvMed has contracted or made arrangements to render the professional Health Care Services set forth herein to AvMed Achieve Plan Members. For a listing of AvMed Achieve Plan Participating (In-Network) Physicians and Providers, please refer to your Provider Directory or visit our online directory at [www.avmed.org](http://www.avmed.org).
- 2.58 **Physician** means any provider licensed under Chapter 458 (Physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes*.

- 2.59 **Premium** means the total amount of monthly prepayment subscription charges required to be paid by the Subscribing Group to AvMed in order for there to be coverage under this Contract.
- 2.60 **Prescription Medication or Prescription Drug** means a medication that has been 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. PHARMACY MEDICATION BENEFITS.
- 2.61 **Primary Care Physician (PCP)** means any Achieve Plan Participating Physician engaged in general or family practice, pediatrics, internal medicine, 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 Participating Physicians and Hospitals. A PCP is one who directly provides or coordinates a range of Health Care Services for a Member.
- 2.62 **Prior Authorization** means a decision by AvMed, prior to the time a Health Care Service or other benefit is to be delivered, that the Health Care Services are Medically Necessary. Prior Authorization is sometimes called pre-authorization, prior approval or pre-certification. AvMed requires you or your Physician 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.
- 2.63 **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.
- 2.64 **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 and outpatient settings.
- 2.65 **Residential Treatment** is a 24-hour intensive, structured and supervised treatment program providing an inpatient level of care but in a non-Hospital environment, and is utilized for those disorders that cannot be effectively treated in an outpatient or Partial Hospitalization environment.
- 2.66 **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.
- 2.67 **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 In-Network coverage under AvMed's Small Group Achieve Plans is available.
- 2.68 **Skilled Nursing Facility** means an institution or part thereof which is licensed as a Skilled Nursing Facility by the State of Florida, 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, and with which AvMed has contracted or made arrangements for the provision of appropriate services.
- 2.69 **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.
- 2.70 **Specialty Physician** means any Participating Physician licensed under Chapter 458 (Physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes*, other than the Member's PCP.
- 2.71 **Subscriber** means an employee of the Subscribing Group who meets all applicable requirements of Part III. ELIGIBILITY FOR COVERAGE, enrolls in the Plan, and for whom the Premium prepayment required by Part VI. MONTHLY PREMIUM PAYMENTS, COPAYMENTS, COINSURANCE AND DEDUCTIBLES, has actually been received by AvMed.

- 2.72 **Subscribing Group** means a corporation, partnership, limited liability company or other legal entity (and its wholly-owned subsidiaries) that negotiates and agrees to contract for the Health Care Services and benefits provided herein for its Eligible Employees.
- 2.73 **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.
- 2.74 **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.
- 2.75 **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.
- 2.76 **Total Disability** means a totally disabling Condition resulting from an illness or injury which prevents the 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.
- 2.77 **Urgent Care Center** means a facility properly 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.
- 2.78 **Urgent Medical Condition** means a Condition manifesting itself by acute symptoms that are of lesser severity than that 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.
- 2.79 **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.
- 2.80 **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.
- 2.81 **Ventilator Dependent Care** means care, other than acute Hospital care, received in any facility which provides services to ventilator dependent patients, including all types of facilities known as sub-acute care units, ventilator dependent units, alternative care units, sub-acute care centers and all other like facilities, whether maintained in a free standing facility or maintained in a Hospital or Skilled Nursing Facility setting.

### III. ELIGIBILITY FOR COVERAGE

Any employee and the dependents of an employee who meet and continue to meet the eligibility requirements described in this Contract, shall be entitled to apply for 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 Subscriber as the legal guardian, or appropriate adoption documentation, as described in Part IV. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE).

#### 3.1 **Subscriber Eligibility.**

- a. To be eligible to enroll as a Subscriber, a person must be:
  - i. an employee of the Subscribing Group who works the required number of hours per week as set forth in the Master Application for this Contract. The employee must either work or reside in the Achieve Plan Service Area; and
  - ii. employed for the period of time required for eligibility as set forth in the Master Application; and
  - iii. entitled on his own behalf to participate in the medical and Hospital care benefits arranged by the Subscribing Group under this Contract.

#### 3.2 **Dependent Eligibility.**

- a. To be eligible to enroll as a Covered Dependent, a person must be:
  - i. the spouse of the Subscriber under a legally valid existing marriage (other than during open enrollment, a new spouse must be enrolled within 30 days after the date of the marriage); or
  - ii. the Domestic Partner of the Subscriber (the domestic partnership must be sworn upon by affidavit of the Subscriber); or
  - iii. a child of the Subscriber, the Subscriber's covered spouse or the Subscriber's Covered Domestic Partner, provided that the following conditions apply:
    - 1) The child is under the age of 26; and
    - 2) The natural child or stepchild of the Subscriber or the Subscriber's covered Domestic Partner;
    - 3) A legally adopted child in the custody of the Subscriber or the Subscriber's covered Domestic Partner (except as provided for newborns, newly acquired dependent children must be enrolled within 30 days after the date they become eligible for coverage; and written evidence of adoption must be furnished to AvMed upon request);
    - 4) A child for whom the Subscriber, the Subscriber's covered spouse or the Subscriber's covered Domestic Partner has been appointed legal guardian pursuant to a valid court order (such court order must be furnished to AvMed upon request); or
    - 5) The newborn child of a Covered Dependent of the Subscriber, other than the Subscriber's spouse or Domestic Partner (such coverage terminates 18 months after the birth of the newborn child).

#### 3.3 **Extended Coverage for Dependent Children.**

- a. Dependent Children Aged 26 to 30. An Eligible Dependent child who meets the following requirements may be eligible for coverage until the end of the Calendar Year in which the child reaches age 30, if the child:
  - i. is unmarried and does not have a dependent of his own;
  - ii. resides within the Service Area, or is a Full-Time or Part-Time Student; and
  - iii. is not provided coverage under any other group, blanket or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.
  - iv. Such child is not eligible to be covered unless the child was continuously covered by other creditable coverage without a gap in coverage of more than 63 days.

- b. Dependent Students on Medically Necessary Leave of Absence. 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:
  - i. one year after the Medically Necessary leave of absence begins; or
  - ii. the date coverage would otherwise terminate under the Contract.
  - iii. 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.
  - iv. 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.
- c. Children with Disabilities. Attainment of the limiting age by an Eligible Dependent child shall 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 mental retardation or physical handicap; and
  - ii. chiefly dependent upon the Subscriber for support and maintenance, provided proof of such incapacity and dependency is furnished to AvMed by the Subscriber 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.

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

3.5 **Notification Requirement.** It is the Subscriber's responsibility to notify AvMed when a Covered Dependent no longer meets the eligibility requirements set forth herein. Termination of coverage may be retroactively applied if AvMed is not notified within 30 days after the date a dependent who is enrolled as a Covered Dependent is no longer eligible. Subscribers agree to provide supporting documentation upon request by AvMed.

3.6 **Eligibility Requirements Control.** The eligibility requirements set forth herein shall at all times control and no coverage contrary thereto shall be effective. Coverage shall not be implied due to clerical or administrative errors if such coverage would be contrary to this Part III (see also Section 17.4).

3.7 **Enrollment Restriction.** No person is eligible to enroll hereunder who has had his coverage previously terminated under Section 5.4b, except with the written approval of AvMed.

#### **IV. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE**

Any individual who is not properly enrolled hereunder will not be covered under this Contract. AvMed will have no obligation whatsoever to any individual who is not properly enrolled.

4.1 **Open Enrollment.** During the annual open enrollment period each year any Eligible Employee, on behalf of himself and his Eligible Dependents, may elect to enroll in the Plan. Eligible Employees and Eligible Dependents who enroll during the open enrollment period will be covered Members as of the Effective Date of this Contract or subsequent anniversary thereof.

4.2 **Enrollment Timeline.** Outside of the annual open enrollment period, and except as provided for newborns, Eligible Employees and their Eligible Dependents, as described in Sections 3.1 and 3.2, must enroll within 30 days after the date of becoming eligible by submitting any application, enrollment or status change forms acceptable to or provided by AvMed along with any supporting documentation we require;

otherwise, Eligible Employees and Eligible Dependents may not enroll until the next annual open enrollment period.

**4.3 Special Enrollment.** Under the circumstances described below, an Eligible Employee or Eligible Dependent may request to enroll in the Plan outside of the annual open enrollment period.

a. If an Eligible Employee or their Eligible Dependent declined coverage under the Plan when it was first offered because of other group health plan or insurance coverage, and such coverage is lost as a result of any of the following qualifying events, the loss of other coverage triggers a special enrollment period. Loss of coverage due to an individual's failure to pay Premiums (including COBRA Premiums) on a timely basis, or termination of coverage for cause (fraud, intentional misrepresentation, etc.), will not trigger a special enrollment period.

- i. Exhaustion of COBRA continuation coverage;
- ii. Termination of employment or reduction in hours of employment;
- iii. Termination of employer Premium contributions;
- iv. Legal separation, divorce or annulment;
- v. Change in dependent status;
- vi. Death of an employee;
- vii. Change in legal custody or legal guardianship;
- viii. Relocation out of an HMO service area;
- ix. Gaining eligibility for Premium assistance subsidy, or termination of coverage due to loss of eligibility, under Medicaid or the Children's Health Insurance Plan (CHIP).

b. If a Subscriber acquires a new dependent (or dependents) as a result of any of the following qualifying events, the Subscriber may enroll the new dependent during the special enrollment period; or, if an Eligible Employee acquires a new dependent (or dependents) as a result of any of the following qualifying events, the Eligible Employee, on behalf of himself and his new dependent, may enroll during the special enrollment period. Dependents must meet the eligibility requirements as described in Section 3.2.

- i. Marriage;
- ii. Birth; or
- iii. Adoption or placement for adoption.

c. In order for coverage to become effective, a completed application or status change form, and supporting documentation as we may require, must be received by us as specified below.

**4.4 Special Enrollment Timeline.**

a. Except as provided for newborns, Subscribers' Eligible Dependents, or Eligible Employees on behalf of themselves and their Eligible Dependents, must enroll within 30 days after the date of becoming eligible by submitting any enrollment or status change forms acceptable to or provided by AvMed and any supporting documentation we require. If a request to enroll is not received within the time frames specified below, the Eligible Employee and Eligible Dependents must wait until the Subscribing Group's next open enrollment period.

- i. Within 30 days after the date of the loss of other coverage;
- ii. Within 30 days after the date of marriage, adoption or placement for adoption;
- iii. Within 60 days after the birth of a child, including an adopted newborn child, as described in Section 4.5;
- iv. Within 60 days after gaining eligibility for Premium assistance, or loss of eligibility, under Medicaid or CHIP.

**4.5 Newborn Child Notification.** In the case of a newborn child, AvMed should be notified in writing of the Subscriber's intention to enroll the newborn child.

- a. If notice is given within 30 days after the date of birth, no additional Premium will be charged for the newborn child's coverage during the 30 day period following the newborn's birth.
- b. If notice is received within 31 to 60 days after the date of birth, we will charge the applicable Premium from the moment of birth. You must pay the additional Premium for coverage to be provided to the newborn child.
- c. If notice is not provided within 60 days after the date of birth, the child may not be enrolled until the Subscribing Group's next open enrollment period.

4.6 **Effective Date of Coverage for Special Enrollments.** The effective dates described below are dependent upon the timely receipt by AvMed of any enrollment or status change forms and supporting information we may require. In order for coverage to become effective, such information must be received by AvMed within the time frames specified above. If the request to enroll is received within the time frames specified, coverage shall become effective as shown; otherwise, a Subscriber's Eligible Dependent, or an Eligible Employee on behalf of himself and his Eligible Dependent may not enroll until the next annual open enrollment period.

- a. General Effective Date. Except as provided for newborns and adopted children (including adopted newborns), the Effective Date of any coverage provided by AvMed will be the first day of the first month following the date of the qualifying event.
- b. Newborns and Adopted Newborns. The Effective Date of any coverage provided by AvMed for a newborn child will be the moment of birth. For adopted newborns, coverage will be effective from the moment of birth provided a written agreement to adopt such child was entered into by the Subscriber prior to the birth of the child; however, coverage shall not be effective if the child is not ultimately placed in the Subscriber's residence, in compliance with Chapter 63, *Florida Statutes*.
- c. Adopted Children. For adopted children who are not newborns, the Effective Date of any coverage provided by AvMed will be the moment of placement in the Subscriber's residence; however, coverage shall not be effective if the child is not ultimately placed in the Subscriber's residence, in compliance with Chapter 63, *Florida Statutes*.

4.7 **Minimum Enrollment Requirement.** This Contract, at the sole option of AvMed, will not be accepted if at the time of the renewal offering to the Subscribing Group, the total enrollment does not result in a predetermined minimum enrollment as established by AvMed, pursuant to Florida law. The required minimum group enrollment is included in the Rate Letter (as defined in Section 17.25) furnished to the Subscribing Group.

## V. TERMINATION

5.1 **Contract Term.** This Contract shall continue in effect for one year from the Effective Date hereof, and may be renewed from year to year thereafter, subject to the following termination provisions. Additionally, the Subscribing Group must meet group eligibility guidelines at each renewal period as specified in the Rate Letter to the Subscribing Group. Prior to the Subscribing Group's Contract anniversary date, AvMed will request written documentation to verify eligibility and participation requirements. Failure to timely return the appropriate documentation will result in the termination of this Group Contract on the Subscribing Group's anniversary date.

5.2 **Termination of Group Contract by Subscribing Group.**

- a. Termination on Anniversary Date. The Subscribing Group may terminate this Group Contract on the anniversary date by giving written notice to AvMed 15 days prior to the Contract anniversary date. In such event, benefits hereunder shall terminate for all Members at 12:00 a.m. (midnight) on the Group Contract expiration date.
- b. Early Termination. The Subscribing Group may terminate this Group Contract by giving AvMed at least 45 days prior written notice. In such event, benefits hereunder shall terminate for all Members at 12:00 a.m. (midnight) on the date specified by the Subscribing Group in their written notice to AvMed and for which the Premium was paid.

5.3 **Termination of Group Contract by AvMed.** AvMed may non-renew or discontinue this Group Contract based on one or more of the conditions listed below. In such event, benefits hereunder shall automatically terminate for all Members at 12:00 a.m. (midnight) on the Contract termination date as described below.

- a. Failure to Make Premium Payment. If the Subscribing Group fails to make payment of the monthly Premium by the Premium due date and within the Grace Period, as provided in Section 6.1, coverage hereunder shall terminate for all Members for whom Premium payment has not been received, on the last day for which the monthly Premium was received. Coverage will remain in effect during the Grace Period; however, if Premium payments are not received by the end of the Grace Period, late payment fees may apply and AvMed may retroactively terminate the Subscribing Group's coverage as described below:
  - i. Retroactive Termination. AvMed will provide the Subscribing Group with notice of cancellation prior to the 45<sup>th</sup> day after the Premium due date. Such notice will be mailed to the Subscribing Group's last address provided to AvMed, and may provide for retroactive cancellation back to 12:00 a.m. (midnight) on the date the Premium was due.
- b. Fraud/Material Misrepresentation. If the Subscribing Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Contract, the Subscribing Group's coverage will be immediately terminated.
- c. Breach of Material Contract Provision. If the Subscribing Group has failed to comply with a material provision of the Contract that relates to rules for employer Premium contributions or group participation, termination will be effective upon 45 days written notice from AvMed to the Subscribing Group.
- d. No Enrollees in Service Area. If there are no longer any enrollees in connection with the Plan who work or reside in the Service Area, termination of coverage will be effective on the last day of the month for which Premium payments were received by AvMed.
- e. Coverage Ceases in Applicable Market. If AvMed ceases to offer coverage in the applicable market, AvMed will provide written notice to Subscribing Group at least 180 days prior to such termination.

5.4 **Termination of a Member's Coverage.**

- a. Loss of Eligibility. Subject to the continuation rights under Section 5.8:
  - i. Upon the loss of a Subscriber's eligibility as defined in Part III. ELIGIBILITY FOR COVERAGE, coverage for the Subscriber and the Subscriber's Covered Dependents, if any, shall automatically terminate at 12:00 a.m. (midnight) on the last day of the month for which the monthly Premium was paid and during which the Subscriber was eligible for coverage.
  - ii. Upon the loss of a Covered Dependent's eligibility as defined in Part III. ELIGIBILITY FOR COVERAGE, coverage shall automatically terminate at 12:00 a.m. (midnight) on the last day of the month for which the monthly Premium was paid and during which the Covered Dependent was eligible for coverage.
- b. Termination of Coverage for Cause.
  - i. AvMed may terminate any Member immediately upon written notice for the following reasons which lead to a loss of eligibility of the Member:
    - 1) fraud, Material Misrepresentation or omission in applying for membership, benefits or coverage under this Contract. However, relative to a misstatement in the Application, after two years from the issue date, only fraudulent misstatements in the Application may be used to void the Contract or deny any Claim for a loss occurred or disability starting after the two year period;
    - 2) misuse of AvMed's Identification Card furnished to the Member;
    - 3) furnishing to AvMed incorrect or incomplete information for the purpose of obtaining membership, coverage or benefits under this Contract; or
    - 4) behavior which is disruptive, unruly, abusive or uncooperative to the extent that the Member's continuing coverage under this Contract seriously impairs AvMed's ability to administer this

Contract or to arrange for the delivery of Health Care Services to the Member or other Members, after AvMed has attempted to resolve the Member's problem.

**5.5 Notification Requirements.**

- a. Loss of Eligibility of Subscriber. It is the responsibility of Subscribing Group to notify AvMed in writing within 30 days after the effective date of termination regarding any Subscriber or Covered Dependent who becomes ineligible to participate in the Plan. Failure of the Subscribing Group to provide timely written notice may lead to retroactive termination of the Subscriber or Covered Dependent. The effective date for such retroactive termination will be the last day of the month for which the Premium was received by AvMed and during which the Subscriber and any Covered Dependents were eligible for coverage. Retroactive adjustments in coverage will only be done for up to a 60-day period from the date of notification.
- b. Loss of Eligibility of a Covered Dependent. When a Subscriber's Covered Dependent becomes ineligible for coverage, the Subscriber is required to notify AvMed in writing within 30 days after the date of the dependent's loss of eligibility.
- c. Contract Termination. In the event this Contract is terminated, the Subscribing Group agrees to provide to its employees who are Subscribers under this Contract written notification 45 days prior to the date of such termination; and AvMed will be deemed to have complied with its notification requirements.

**5.6 AvMed's Obligations upon Termination.** Upon termination of your coverage for any reason, we will have no further liability or responsibility to you under this Contract, except as specifically described herein. In the event of retroactive termination due to the Subscribing Group's nonpayment of Premiums or failure to timely notify AvMed of Member ineligibility, AvMed shall not be responsible for Claims incurred by AvMed in arranging for the provision of benefits to Members under the terms of this Contract after the effective date of such retroactive termination. In such event, AvMed reserves the right to recover an amount equal to the Allowed Amount or Maximum Allowable Payment for any benefits received by Members after the effective date of termination, less any Premiums received by us for such Member's coverage after such date.

**5.7 Refund of Premiums.** Premiums paid to AvMed by the Subscribing Group for any Member after the date on which that Member's eligibility ceased, or the Member was terminated, shall be refunded on a pro rata basis, and limited to the total excess Premium amounts paid, up to a maximum of 60 days from the date of such ineligibility or termination, less any Claims incurred after the effective date of termination. Any unearned portion of prepaid Premiums will be returned to the Subscribing Group.

**5.8 Continuation Coverage under COBRA.** Under certain provisions of COBRA, the Subscriber or his Covered Dependents may elect continued coverage under the Plan if coverage is lost due to a qualifying event.

a. Eligibility.

- i. Subscribers or their Covered Dependents will become eligible for continuation coverage under COBRA after any of the following qualifying events result in the loss of Plan coverage:
  - 1) loss of benefits due to a reduction in hours of employment;
  - 2) termination of employment, including retirement but excluding termination for gross misconduct;
  - 3) termination of employment following leave under the Family and Medical Leave Act of 1993 (FMLA), in which case the qualifying event will occur on the earlier of the date you indicated you were not returning to work or the last day of the FMLA leave; or
  - 4) the Subscriber or a Covered Dependent first becomes entitled to Medicare or covered under another group health plan prior to the loss of coverage due to termination of employment or reduction in hours.
- ii. A Subscriber's Covered Dependents will become eligible for COBRA continuation coverage after any of the following qualifying events occur to cause a loss of Plan coverage:
  - 1) the Subscriber's death;

- 2) divorce or legal separation;
  - 3) the Subscriber first becomes entitled to Medicare after a loss of coverage due to termination of employment or reduction in hours; or
  - 4) the Subscriber's dependent child no longer qualifies as an Eligible Dependent under the Plan.
- iii. A child who is born to (or placed for adoption with) a covered former employee during the continuation coverage period has the same continuation coverage rights as a Covered Dependent child described above.
- b. **Notification.** If a qualifying event other than divorce, legal separation, loss of Eligible Dependent status or entitlement to Medicare occurs, the Plan Administrator will be notified of the qualifying event by the Subscriber's employer and will send the Subscriber an election form. To continue Plan coverage, the election form must be returned within 60 days from the later of the date it is received or the date coverage ends due to a qualifying event.
- i. If divorce, legal separation, loss of Eligible Dependent status or entitlement to Medicare under the Plan occurs, the Subscriber must notify the Plan Administrator that a qualifying event has occurred. This notification must be received by the Plan Administrator within 60 days after the later of the date of such event, or the date the Subscriber or Dependent would lose coverage on account of such event. Failure to promptly notify the Plan Administrator of these events will result in loss of the right of the Subscriber and Covered Dependents to continue coverage.
  - ii. After receiving this notice, the Plan Administrator will send an election form to the Subscriber within 14 days. If the Subscriber or his Covered Dependents wish to elect continuation coverage, the election form must be returned to the Plan Administrator within 60 days from the later of the date it is received or the date coverage ends due to the qualifying event.
- c. **Cost.** If you elect to continue coverage, you must pay the entire cost of coverage (both the employer's Premium contribution and the active employee portion of the Premium), plus a 2% administrative fee for the duration of COBRA continuation coverage.
- i. If a Subscriber or Covered Dependent is Social Security disabled (Social Security disability status must occur as defined by Title II or Title XVI of the Social Security Act), continuation coverage may be elected for the disabled person only or for some or all of COBRA eligible family members for up to 29 months if the Subscriber's employment is terminated or hours are reduced. The Subscriber must pay 102% of the cost of coverage for the first 18 months of COBRA continuation coverage and 150% of the cost of coverage for the 19th through the 29th months of coverage. The Social Security disability date must occur within the first 60 days of loss of coverage due to the termination of employment or reduction in hours.
  - ii. For COBRA coverage to remain in effect, payment must be received by the Plan Administrator by the first day of the month for which the Premium is due. (The first payment is due no later than 45 days after the election to continue coverage, and must cover the period of time back to the first day of COBRA continuation coverage.)
- d. **Duration.** COBRA continuation coverage can be extended for:
- i. 18 months if coverage ended due to a reduction in work hours or termination of employment and the Subscriber or one of his Covered Dependents is not Social Security disabled within 60 days of the date of the loss of coverage due to termination of employment or reduction in hours, the Medicare entitled person may elect up to 18 months of COBRA. If the Subscriber is that Medicare entitled person, the Subscriber's Covered Dependents may elect COBRA for the longer of 36 months from the Subscriber's prior Medicare entitlement date, or 18 months from the date of the termination or reduction in hours; or
  - ii. 36 months for Covered Dependents of the Subscriber if those dependents lose eligibility for medical coverage due to the Subscriber's death, divorce or legal separation, entitlement to Medicare after termination or reduction in hours, or a Covered Dependent child ceasing to qualify as an Eligible Dependent under the Plan; or
  - iii. 29 months if coverage is lost due to termination of employment or reduction in hours and the Subscriber or a Covered Dependent is disabled, as defined by Title II or Title XVI of the Social

- Security Act, within 60 days of the original qualifying event. In this case, coverage may be continued for an additional 11 months after the original 18-month period either for the disabled person only or for one or all of the covered family members; or
- iv. To be eligible for extended coverage due to Social Security disability, a Subscriber must notify the Plan Administrator of the disability before the end of the initial 18 months of COBRA continuation coverage and within 60 days after the date the Subscriber or a Covered Dependent is determined to be disabled by the Social Security Administration. If the disabled individual should no longer be considered to be disabled by the Social Security Administration, the Subscriber must notify the Plan Administrator within 30 days after the end of the disability. Coverage that has exceeded the original 18-month continuation period will end when the individual is no longer Social Security disabled.
  - v. If more than one qualifying event occurs, no more than 36 months total of COBRA continuation coverage will be available. The COBRA beneficiary must experience the second qualifying event during the first 18 months of COBRA continuation coverage, and must provide notice to the Plan Administrator within the required time period. COBRA continuation coverage will end sooner if the Plan terminates and the employer does not provide replacement medical coverage, or if a person covered under COBRA:
    - 1) first becomes covered under another group health plan after the loss of coverage due to a termination or reduction in hours, provided appropriate Premium payments for COBRA coverage continue to be paid. Coverage may only continue for the remainder of the original COBRA period;
    - 2) fails to pay the full amount of the applicable COBRA Premium when due;
    - 3) first becomes entitled to Medicare benefits after the initial COBRA qualifying event; or
    - 4) is extending the 18-month coverage period because of disability and is no longer disabled as defined by the Social Security Act.

#### 5.9 Continuation Coverage during Leaves of Absence.

- a. Family and Medical Leaves of Absence (FMLA). Under FMLA, a Subscriber may be entitled to up to a total of 12 weeks of unpaid, job-protected leave during each Calendar Year for the following:
  - i. the birth of the Subscriber's child, to care for the newborn child, or for placement of a child in the Subscriber's home for adoption or foster care;
  - ii. to care for a spouse, child or parent with a serious health condition; or
  - iii. for the Subscriber's own serious health condition.
  - iv. If the FMLA leave is paid, such pay will be reduced by the Subscriber's before-tax Premium contributions as usual for the coverage level in effect on the date FMLA leave begins. If FMLA leave is unpaid, the Subscriber will be required to pay Premium contributions directly to the employer until returning to active pay status.
  - v. If a Subscriber notifies the employer that he or she is terminating employment during FMLA leave, coverage will end on the date of notification. If the Subscriber does not return to work on the expected FMLA return date, and the employer is not notified of the intent to either terminate employment or extend the period of leave, coverage will end on the date the Subscriber was expected to return.
  - vi. Plan elections may not be changed during FMLA leave unless an open enrollment occurs and the Subscriber has a change in status event or a special enrollment event under The Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- b. Military Caregiver Leave Entitlements. Subscribers who need to provide care for injured service members may also be eligible for FMLA as follows. FMLA leave for this purpose is called "military caregiver leave". Military caregiver leave allows an eligible Subscriber who is the spouse, son, daughter, parent or next of kin of a covered service member with a serious injury or illness to take up to a total of 26 workweeks of unpaid leave during a single 12-month period to provide care for the service member. A covered service member is a current member of the Armed Forces, including a member of

the National Guard or Reserves, who is receiving medical treatment, recuperation, or therapy, or is in outpatient status, or is on the temporary disability retired list for a serious injury or illness.

- c. Military Leaves of Absence. If a Subscriber is absent from work due to military service, continuation coverage under the Plan (including coverage for Covered Dependents) may be elected for up to 18 months from the first day of absence (or if earlier, until the day after the date the Subscriber is required to apply for or return to active employment with the employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)). The Subscriber's Premium contributions for continued coverage will be the same as for similarly situated active Members in the Plan.
  - i. Whether or not coverage is continued during military service, a Subscriber may reinstate coverage under the Plan option elected on return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that any required waiting period was not completed prior to the start of the military service.

**5.10 Extension of Benefits.** In the event this Contract is terminated for any reason, except nonpayment of Premium or as set forth in this Section, such termination shall be without prejudice to any continuous losses to a Member which commenced while this Contract was in force, but any extension of benefits beyond the date of termination shall be predicated upon the Member's continuous Total Disability, as defined in Section 2.76, and shall be limited to payment for the treatment of a specific accident or illness incurred while coverage under this Contract was effective.

- a. The extension of benefits covered under this Contract shall be limited to the occurrence of the earliest of the following events:
  - i. the expiration of 12 months;
  - ii. such time as the Member is no longer totally disabled;
  - iii. a succeeding carrier elects to provide replacement coverage without limitation as to the disability condition; or
  - iv. the maximum benefits payable under this Contract have been paid.
- b. In the case of maternity coverage, when not covered by the succeeding carrier, a reasonable extension of this Contract's benefits will be provided to cover maternity expenses for a covered pregnancy that commenced while the policy was in effect. The extension shall be for the period of that pregnancy only and shall not be based upon Total Disability.
- c. Except as provided above, no Subscriber is entitled to an extension of benefits if the termination by AvMed of this Contract is based upon one or more of the following reasons:
  - i. fraud or intentional misrepresentation in applying for any benefits under this Contract;
  - ii. disenrollment for cause; or
  - iii. the Subscriber has left the Achieve Plan Service Area with the intent to work and reside outside the Achieve Plan Service Area.

**5.11 Guaranteed Availability of Coverage.**

- a. Conversion after Continuation Coverage. Federal law provides for the guaranteed availability of coverage, when continuation coverage as provided under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) expires. Under these provisions, the Subscriber or Covered Dependent may be eligible for coverage under an AvMed Individual Contract, and may apply by completing a coverage application form. Coverage is subject to AvMed's eligibility requirements and enrollment may be limited to annual open enrollment periods. To be considered for coverage outside of the annual open enrollment period, subject to the rules of special enrollment listed in Section 4.3, the required Premium payment, along with proof of a qualifying event and completed enrollment application form must be submitted to:

AvMed Individual Sales  
Accounts Receivable  
9400 South Dadeland Blvd.

## VI. MONTHLY PREMIUM PAYMENTS, COPAYMENTS, COINSURANCE AND DEDUCTIBLES

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

### 6.1 **Subscribing Group's Obligations.**

- a. Monthly Premium Payment. On or before the first day of each month for which coverage is sought, Subscribing Group or its designated agent shall remit to AvMed, on behalf of each Subscriber and his Covered Dependents, the monthly Premium based on the Rate Letter and Master Application. Only Members for whom the stipulated payment is actually received by AvMed shall be entitled to the Health Care Services covered under this Contract and then only for the period for which such payment is applicable.
- b. Grace Period. This Contract has a 20-day Grace Period. This provision means that if any required Premium is not paid on or before the date it is due, it must be paid during the Grace Period. The Contract will remain in force during the Grace Period; however, if payment is not received by the last day of the Grace Period, termination of this Contract for nonpayment of the Premium will be retroactive to 12:00 a.m. (midnight) on the last day for which the Premium was received by AvMed, unless Premium payment has otherwise been contractually adjusted and specified by the parties in a fully executed addendum to this Contract. Acceptance of payment received after the Grace Period shall be solely at AvMed's discretion and may be subject to late payment fees.

### 6.2 **Member's Obligations.**

- a. Calendar Year Deductible. This amount, when applicable, must be satisfied each Calendar Year before AvMed's payment toward Covered Services will begin. Only those expenses for Covered Services submitted on Claims to AvMed will be credited toward the Calendar Year Deductible. Certain Covered Services may not be subject to the Calendar Year Deductible, as shown in your Schedule of Benefits.
  - i. Individual Calendar Year Deductible. The Individual Calendar Year Deductible, when applicable, must be satisfied by each Member each Calendar Year before AvMed's payment toward Covered Services will begin during that Calendar Year.
  - ii. Family Calendar Year Deductible. The Family Calendar Year Deductible, when applicable, may be satisfied by any combination of two or more family members meeting the Family Deductible amount. The maximum amount that any one Member in your family can contribute toward the Family Calendar Year Deductible is the amount credited toward the Individual Calendar Year Deductible. Once the Family Calendar Year Deductible has been satisfied, no other Member of the family will have any additional Calendar Year Deductible responsibility for the remainder of that Calendar Year.
  - iii. Same Calendar Year Look-Back Credit. This provision means that any eligible expense incurred by a Member while covered under the Subscribing Group's prior carrier will be credited toward satisfaction of the Calendar Year Deductible and Out-of-Pocket Maximum under this Plan if:
    - 1) the expenses were incurred before the Effective Date of this Plan but within the same Calendar Year; and
    - 2) the expenses were applied toward satisfaction of the Deductible or Out-of-Pocket Maximum under the prior coverage before the Effective Date of this Plan but within the same Calendar Year; and

- 3) the expenses were for items or services that are Covered Benefits under this Contract. However, in order to receive credit, you may be required to provide AvMed written proof of what has been paid by the prior carrier.
- b. Copayment and Coinsurance Requirements. Covered Services rendered by certain Health Care Providers at certain locations or settings will be subject to a Copayment or Coinsurance requirement. This is the fixed dollar amount (Copayment) or percentage of the Allowed Amount (Coinsurance) you have to pay when you receive these services. Please refer to your Schedule of Benefits for particular Covered Services which 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 Allowed Amount for Covered Services.
- c. Calendar Year Out-of-Pocket Maximum. Deductible, Copayment and Coinsurance amounts paid for Covered Benefits received during the Calendar Year will accumulate toward the Calendar Year Out-of-Pocket Maximum. Services and expenses that are not Covered Benefits will not accumulate toward the Calendar Year Out-of-Pocket Maximum.
  - i. Individual Calendar Year Out-of-Pocket Maximum. Once a Member reaches the Individual Calendar Year Out-of-Pocket Maximum amount shown in your Schedule of Benefits, we will pay for Covered Services received by that Member during the remainder of the Calendar Year at 100% of the Allowed Amount.
  - ii. Family Calendar Year Out-of-Pocket Maximum. If your Contract includes a 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. The maximum amount any one Member in your family can contribute toward the Family Calendar Year Out-of-Pocket Maximum is the amount applied toward the Individual Calendar Year Out-of-Pocket Maximum.
  - iii. 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.

6.3 **Additional Expenses You Must Pay.** In addition to your share of the expenses 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.

6.4 **Estimate of Cost for Covered Services.** You may obtain an estimate of the cost for particular services from Participating Physicians and 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 that the particular service is a Covered Service. All terms and conditions included in your Contract apply.

## **VII. PHYSICIANS, HOSPITALS AND OTHER PROVIDER OPTIONS**

7.1 **Provider and Service Arrangement.** AvMed is committed to arranging for comprehensive prepaid Health Care Services rendered to its Members through the Achieve Plan's network of contracted independent Physicians and Hospitals and other independent Health Care 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 of a Member shall not be subject to modification by AvMed or its Board of Directors, officers or administrators. However, this Section is not intended to and shall not restrict any Utilization Management Program established by AvMed.

- 7.2 **Primary Care Physician Selection.** With the AvMed Achieve Plan, each Member may select a PCP upon enrollment, but is not required to do so. Although you have the option to select any provider you choose, we encourage you to select and develop a relationship with a PCP.
- 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 also 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 us 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. PCP selections cannot be changed more than once per month.
- 7.3 **Specialty Physicians.** You are entitled to see participating Specialty Physicians. A referral from your PCP may be required for certain types of Specialty Physicians, and Prior Authorization may be required from AvMed for certain services.
- 7.4 **Provider Directory.** The names and addresses of Achieve Plan Participating Providers and Hospitals are set forth in a separate booklet which, by reference, is made a part hereof. The list of Participating Providers, which may change from time to time, will be provided to all Subscribing Groups. The list of Participating Providers may also be accessed from AvMed's website at [www.avmed.org](http://www.avmed.org). Health Professionals may from time to time cease their affiliation with AvMed. In such cases, Members may be required to receive services from another participating Health Professional. Notwithstanding the printed booklet, the names and addresses of Participating Providers on file with AvMed at any given time shall constitute the official and controlling list of Participating 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/HOW TO APPEAL A CLAIM (BENEFIT DENIAL).

## **VIII. 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 Participating Physicians and Providers, in conformity with Part II. DEFINITIONS, Part IX. COVERED SERVICE CATEGORIES, Part X. LIMITATIONS OF COVERED SERVICES, Part XI. EXCLUSIONS FROM COVERED SERVICES, and the Schedule of Benefits, which by reference is incorporated herein. Except for Emergency Medical Services and Care as provided in Section 9.20, all services must be received from Participating Physicians and Providers within the Service Area, and AvMed shall have no liability or obligation whatsoever on account of services or benefits sought or received by any Member from any Non-Participating Physician, 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.
- 8.2 **Pre-existing condition exclusions are not applicable** under this Contract.
- 8.3 **Medicare Secondary Payer Provision.** When you become covered under Medicare and are still eligible and covered under this Plan, your coverage under this Plan will be primary and Medicare benefits will be secondary, but only to the extent required by law. In all other instances, such as when you turn 65 or

become eligible for Medicare due to a disability other than End Stage Renal Disease (ESRD), your coverage under this Plan will be secondary to any Medicare benefits. In such circumstances, enrolling in Medicare when you are first eligible can maximize your benefits. When your coverage under this Plan is the primary payer, claims for Covered Services should be filed with us first. If you become covered under Medicare and are still eligible and covered under this Plan, the Subscribing Group may not offer, subsidize, procure or provide a Medicare supplement policy to you. Also, an employer may not persuade you to decline or terminate your coverage under this Plan and elect Medicare as the primary payer. When you turn 65 or become eligible for Medicare due to ESRD, you must notify your employer.

- a. Individuals with ESRD. If you become entitled to Medicare coverage because of ESRD, your coverage under this Plan is primary for 30 months beginning with the earlier of:
  - i. the month in which you became entitled to Medicare Part A ESRD benefits; or
  - ii. the first month in which you would have been entitled to Medicare Part A ESRD benefits if a timely application had been made.

8.4 **Care Management Programs.** 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:

- a. provide you with information that will help you make more informed decisions about your health;
- b. help us facilitate the management and review of the coverage and benefits provided under our policies; and
- c. present opportunities as explained below, to mutually agree upon alternative benefits for cost-effective medically appropriate Health Care Services.

8.5 **Inpatient Facility Program.** Under the inpatient facility program, 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.

- a. In administering the inpatient facility program, we may review specific medical facts or information and assess, among other things, the appropriateness of the services being rendered, health care setting or the level of care of an inpatient admission or other health care treatment program. Any such reviews by us, and any reviews or assessments of specific medical facts or information which we conduct, are solely for purposes of making coverage or payment decisions under this Contract and not for the purpose of recommending or providing medical care.
- b. 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.
- c. 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.

8.6 **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.

- b. **Medical Necessity Examples.** Examples of hospitalization and other Health Care Services that are not Medically Necessary include:
  - i. staying in the Hospital because arrangements for discharge have not been completed;
  - ii. 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);
  - iii. 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; or
  - iv. use of laboratory, x-ray, or other diagnostic testing that has no clear indication, or is not expected to alter your treatment.
- c. 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 definitions of 'Medically Necessary' or 'Medical Necessity'.

8.7 **Decision-Making for Health Care Services.** All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for Health Care Services, are solely your responsibility and that of your treating Health Professionals. You and your Health Professionals are responsible for deciding what medical care should be rendered or received and when that care should be provided. We are solely responsible for determining whether expenses incurred for Health Care Services are covered 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 Care Providers. Subscribing Group and Members acknowledge that 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.

8.8 **Member's Responsibility in Seeking Covered Benefits and Services.** You are solely responsible for selecting a provider when obtaining Health Care Services and for verifying whether that provider is a Participating Provider at the time Health Care Services are rendered. You are also responsible for determining any corresponding payment options at the time the Health Care Services are rendered. If a Member does not follow these access rules, he risks having the services and supplies received not covered under this Contract. In such a circumstance, any payment that AvMed may make will not exceed the Maximum Allowable Payment and the Member will be responsible for reimbursing AvMed for the services and supplies received. It is the Member's responsibility when seeking benefits under this Contract to identify himself as a Member of AvMed.

8.9 **Services that Require Prior Authorization.**

- a. Members should 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 Professional that the service has received Prior Authorization. If you are unable to secure verification from your Health Professional, 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);

- 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);
  - iv. radiation oncology;
  - v. certain medications including Injectable Medications, and select medications administered in a Physician's office, an outpatient Hospital or infusion therapy setting;
  - vi. all Home Health Care Services;
  - vii. cardiac rehabilitation;
  - viii. dialysis services;
  - ix. transplant services;
  - x. non-emergency transport services;
  - xi. care rendered by Non-Participating 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 1-800-376-6651. You should always make sure your Physician contacts us to obtain Prior Authorization.

## **IX. COVERED SERVICE CATEGORIES**

### **9.1 Allergy Injections and 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, 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 participating 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 Section 10.1 for applicable benefit maximums and Limitations.
- 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. The speech therapy coverage provided herein is subject to the Limitations shown in Section 10.14. Also see Section 9.38. 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 Medically Necessary.
- 9.9 **Clinical Trials.** 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:
- a. 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; or
  - b. 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
  - c. surgical musculoskeletal disorders of the spine, hip and knees, which are not life-threatening.
  - d. 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.
- e. 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.
- f. Members are required to use a Participating Provider for any clinical trials covered under this Contract.
- g. The clinical trial must meet the criteria described in paragraphs i, ii or iii below:
  - 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;
    - 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.
- h. 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.
- i. 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 shall 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 90 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 Calendar Year in which they turn 19. Services are available from Delta Dental PPO Providers, Delta Dental Premier Providers, or Non-Delta Dental Providers. Services received from Premier or Non-Delta Dental Providers may be subject to fees in excess of the Contracted Fee, as described in Part XVIII. PEDIATRIC DENTAL BENEFITS. Detailed information regarding dental coverage and cost sharing is also included in Part XVIII.

**9.12 Dermatological Services.** AvMed will cover office visits to a dermatologist for Medically Necessary Covered Services subject to Sections 2.49 and 2.80. No prior referral is required for these services.

**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 PCP, 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. Please see Section 9.19.

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

- 9.16 **Diagnostic testing and treatment related to Attention Deficit Hyperactivity Disorder (ADHD)** is covered subject to Sections 2.49 and 2.80. Covered Services do not include those that are primarily educational or training in nature.
- 9.17 **Dialysis services** including equipment, training and medical supplies are covered when provided at an AvMed contracted location by a participating Health Professional licensed to perform dialysis, including an AvMed contracted 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.
- 9.18 **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. Prior Authorization may be required.
- 9.19 **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 fee 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.
  - 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.
- 9.20 **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 a participating 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 emergencies as described in Sections 2.26, and 2.28, while temporarily outside the Service Area, or within the Service Area but before they can reach a Participating Provider, may receive the emergency benefits specified herein. When Emergency Services for an Emergency Medical Condition are rendered by an Out-of-Network Provider, 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 Medical Services and Care, AvMed will pay an amount equal to the greater of the three amounts specified below:
    - i. The median of the amount negotiated with Participating Providers for the Emergency Medical Services and Care furnished;
    - ii. The amount for the emergency service 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. If Emergency Medical Services and Care are required while outside the continental United States, Alaska and 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 Section 13.3d.

**9.21 Habilitation Services.**

- a. Covered Services consist of physical, occupational and speech therapies that are provided for developmental delay, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder. Therapy services must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate state licensing board, and must be furnished under the direction and supervision of a Participating 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.

**9.22 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. You are unable to leave your home without considerable effort and the assistance of another person because you are:
    - 1) bedridden or chair bound or because you are restricted in ambulation whether or not you use assistive devices; or
    - 2) you are significantly limited in physical activities due to a Condition; and
  - ii. The Home Health Care Services rendered have been prescribed by a Participating 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. You are 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 (i.e., a visit of up to, but not exceeding, two hours per day) nursing care by a registered nurse, licensed practical nurse or home health aide services. Home health aide services must be consistent with the plan of treatment ordered by a Participating Physician and rendered under the supervision of a registered nurse;
  - ii. medical social services;
  - iii. nutritional guidance;
  - iv. respiratory, or inhalation therapy (e.g., oxygen); and
  - v. physical therapy by a physical therapist, occupational therapy by an occupational therapist, and speech therapy by a speech therapist.

**9.23 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.

- 9.24 **Hospital Inpatient Care and Services.** Inpatient services received at participating Hospitals are covered when prescribed by Participating 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 Section 9.20, with regard to inpatient admission following Emergency Medical Services and Care.
- 9.25 **Inpatient Rehabilitation Services** are covered when the following criteria are met:
- a. Services must be provided under the direction of a Participating 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.
- 9.26 **Mammograms.** 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. Mammograms are not subject to the Calendar Year Deductible or any cost-sharing.
- 9.27 **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 shall include:
    - i. 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 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.
- 9.28 **Mental Health Services.** Inpatient, intermediate and outpatient mental health services are covered when Medically Necessary and may be covered when a Member is admitted to a participating Hospital or Other Health Care Facility.
- a. For those disorders that cannot be effectively treated in an outpatient or 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. 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.

9.29 **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 shall 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.

9.30 **Non-Participating Provider Services.** When, in the professional judgment of AvMed's Medical Director, a Member needs covered Health Care Services or Hospital services which require skills or facilities not available from Participating Providers, and it is in the best interest of the Member to obtain the needed care from a Non-Participating Provider, upon authorization by the Medical Director, payment will be made not to exceed the Maximum Allowable Payment for such Covered Services rendered by a Non-Participating Provider.

9.31 **Nutrition Therapy.** Prescription-required nutritional supplements and low protein modified foods for use at home by a Member may be covered when prescribed or ordered by a Participating Physician, only for the treatment of an inborn error of metabolism genetic disease, e.g., Disorder of Amino Acid metabolism such as phenylketonuria (PKU), for a Member through the age of 24. Prior Authorization is required for coverage of enteral, parenteral, or oral nutrition and any related supplies. See Part X. LIMITATIONS OF COVERED 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 PCP. 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 a participating 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 participating Health Professionals who specialize in obstetrics or gynecology contact AvMed's Member Engagement Center, or visit us online at [www.avmed.org](http://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 after 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. Birthing Center refers to a facility or institution, other than a Hospital or Ambulatory Surgery Center, which is licensed pursuant to Chapter 383, *Florida Statutes*, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.
- c. 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.** Orthotic devices or appliances means any rigid or semi-rigid device needed to support a weak or deformed body part or to restrict or eliminate body movement. 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 are covered for mental health or substance use disorders that cannot be adequately treated on an outpatient or Partial Hospitalization basis, and no prior Hospital stay is required.
- 9.36 **Outpatient Therapeutic Services.** Covered Services for therapeutic treatments received on an outpatient basis in your home, Physician's office, Other Health Care Facility or Hospital, including intravenous chemotherapy or other intravenous infusion therapy and Injectable Medications.
- 9.37 **Pain Management.** Outpatient pain management including pain assessment, medication, physical therapy, biofeedback and counseling may be covered when Medically Necessary in order to reduce or limit chronic pain.
- 9.38 **Physical, Occupational and Speech Therapies.**
- a. Short term rehabilitative physical, occupational and speech therapies provided in an outpatient or home care setting are covered to improve or restore physical functioning following disease, injury or loss of a body part.
  - b. Habilitative physical, occupational and speech therapies provided in an outpatient setting are covered when provided to help a person keep, learn or improve skills and functioning for daily living.
  - c. Clinical documentation or a treatment plan to support the need for therapy services or continuing therapy must be submitted for review. Please refer to Part X. LIMITATIONS OF COVERED SERVICES for applicable benefit maximums and Limitations, and Part XI. EXCLUSIONS FROM COVERED SERVICES.
  - d. Continued therapy is only Medically Necessary when prescribed by a Participating 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.

- 9.39 **Physician Care: Inpatient.** All Health Care Services rendered by Participating Physicians and other participating Health Professionals when requested or directed by the Attending Physician, including surgical procedures, anesthesia, consultation and treatment by participating Specialty Physicians, laboratory and diagnostic imaging services, and physical therapy are covered while the Member is admitted to a participating 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.
- 9.40 **Physician Care: Outpatient.**
- a. Diagnosis and Treatment. All Health Care Services rendered by Participating Physicians and other participating 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. Such services, materials and supplies are subject to the Limitations outlined in Part X. LIMITATIONS OF COVERED SERVICES and Exclusions as outlined in Part XI. EXCLUSIONS FROM COVERED SERVICES.
  - b. Preventive and Health Maintenance Services. Services of participating 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 United States Preventive Services Task Force (USPSTF) with respect to the Member involved; immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-informed preventive care and screenings for infants, children, and adolescents as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and evidence informed preventive care and screening for women as provided for in comprehensive guidelines supported by the HRSA. A listing of preventive health services with current 'A' or 'B' ratings is available on the USPSTF website. Important note about gender-specific preventive care benefits: Covered expenses include any recommended preventive care benefits described above that are determined by your Health Professional to be Medically Necessary, regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.
- 9.41 **Prescription Medications.** Retail Prescription Medications may be covered when accompanied by a prescription from your Attending Physician. Coverage of retail Prescription Medications is subject to the cost-sharing shown in your Schedule of Benefits. Allergy serums and chemotherapy for cancer patients are covered. Coverage for insulin and other diabetic supplies is described in Section 9.14. 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. See Part XII. PHARMACY MEDICATION BENEFITS for additional information.
- 9.42 **Prosthetic Devices.** This Contract provides benefits, when Medically Necessary, for Prosthetic Devices designed to restore bodily function or replace a physical portion of the body. Coverage for Prosthetic Devices is limited to artificial limbs, artificial joints, and ocular prostheses. Coverage includes the initial purchase, fitting, or adjustment. Replacement is covered only when Medically Necessary due to a change in bodily configuration. The initial Prosthetic Device following a covered mastectomy is also covered. Replacement of intraocular lenses is covered only if there is a change in prescription that cannot be accommodated by eyeglasses. All other Prosthetic Devices are not covered, including Prosthetic Devices for Deluxe, Myo-electric and electronic Prosthetic Devices. The determination of whether a covered item will be paid under the DME, orthotics or prosthetics benefits will be based upon its classification as defined by the Centers for Medicare and Medicaid Services.
- 9.43 **Second Medical Opinions.** Members are entitled to a second medical opinion when disputing the appropriateness or necessity of a surgical procedure, or when subject to a serious injury or illness.
- a. A Member may choose to obtain the second medical opinion from any Participating or Non-Participating Physician. If a Participating Physician is chosen, the applicable office visit cost-sharing

will apply. If a Member chooses a Non-Participating Provider, the Member will be responsible for 40% of the amount of the Maximum Allowable Payment for the second medical opinion.

- b. Once a second medical opinion has been rendered, AvMed shall 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 shall be at the Member's expense. 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.

**9.44 Skilled Nursing Facilities.**

- a. The following Health Care Services may be Covered Services when you are a patient in a Skilled Nursing Facility:
  - i. room and board;
  - ii. respiratory, pulmonary, 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. Please refer to Sections 10.17 and 11.50 for applicable benefit maximums or Limitations.

**9.45 Speech Therapy.** See Section 9.38.

**9.46 Spinal Manipulation.** See Section 9.8.

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

- a. For those disorders that cannot be effectively treated in an outpatient or 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. 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.

**9.48 Supplies.** Ostomy, urostomy and wound care supplies are covered when Medically Necessary.

- a. 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.
- b. Wound care supplies are covered as part of an approved treatment plan, when one of the following criteria is met: treatment of a wound caused by, or treated by, a surgical procedure; or treatment of a wound that requires debridement.

**9.49 Surgical procedures** when performed by a Participating Physician may be covered.

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 below. 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. We will pay benefits only for services, care and treatment received or provided 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 costs 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 the 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 PCP'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 and 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 [Section 13.3d](#).

9.52 **Vision Services (Pediatric Only).** Coverage includes one pediatric vision examination for glasses and one pair of standard eyeglass lenses and frames (from a pre-selected group of frames), or contact lenses, per Calendar Year for children through the end of the month in which they turn 19, as well as consultation and

treatment by participating 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 SERVICES

The rights of Members and obligations of Participating Health Care Providers hereunder are subject to the following Limitations.

- 10.1 **Cardiac Rehabilitation.** Outpatient cardiac rehabilitation, combined with outpatient rehabilitative physical, occupational and speech therapies, and chiropractic services, is limited to 35 visits per Calendar Year. Cardiac rehabilitation requires Prior Authorization.
- 10.2 **Chiropractic Services.** Chiropractic services, combined with outpatient rehabilitative physical, occupational and speech therapies, and cardiac rehabilitation, are limited to 35 visits per Calendar Year.
- 10.3 **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.
- 10.4 **Home Health Care Services (Skilled Home Health Care).** Services are limited to:
  - a. intermittent (i.e., a visit of up to, but not exceeding, two hours per day) nursing care by a registered nurse, licensed practical nurse and/or home health aide services. Home health aide services consistent with a plan of treatment ordered by a Physician and rendered under the supervision of a registered nurse are limited to 20 visits per Calendar Year, including 40 hours of part time services at 8 hours per day;
  - b. medical social services;
  - c. nutritional guidance;
  - d. respiratory or inhalation therapy (e.g., oxygen) and;
  - e. physical therapy by a physical therapist, occupational therapy by an occupational therapist, and speech therapy by a speech therapist.
- 10.5 **Hyperbaric oxygen treatments** are limited to 40 treatments per Condition as appropriate pursuant to the Centers for Medicare and Medicaid Services guidelines, and are subject to the cost-sharing shown in your Schedule of Benefits for physical, occupational and speech therapies.
- 10.6 **Inpatient Acute Rehabilitation Services.** Inpatient acute Rehabilitation Services received in a Hospital are limited to 30 days per Calendar Year.
- 10.7 **Licensed Dietitians/Nutritionists.** Visits to licensed dietitians/nutritionists for treatment of diabetes, renal disease or morbid or non-morbid obesity control are limited to three outpatient visits per Calendar Year.
- 10.8 **Mental health and substance abuse services** in a Residential Treatment facility are limited to a combined maximum of 60 days per Calendar Year.
- 10.9 **Nutrition Therapy.** Prior Authorization is required for coverage of enteral, parenteral, or oral nutrition and any related supplies that exceed \$2,500 in a Calendar Year.
- 10.10 **Orthotic Devices.** Coverage for orthotic devices or 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.
- 10.11 **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, excluding treatment of mental health and substance use disorders (see Section 10.8).
- 10.12 **Prosthetic Devices.** Coverage for Prosthetic Devices is limited to artificial limbs, artificial joints, ocular prostheses and cochlear implants.

- 10.13 **Rehabilitative Physical, Occupational and Speech Therapies.** Outpatient rehabilitative physical, occupational and speech therapies, combined with cardiac rehabilitation and chiropractic services, are limited to 35 visits per Calendar Year, including evaluations.
- 10.14 **Routine Dental and Eye Exams for Children.** Routine dental exams are limited to one exam every six months for children through the end of the year in which they turn 19. 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).
- 10.15 **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.
- 10.16 **Skilled Nursing Facilities and Rehabilitation Centers.** See Section 10.12.
- 10.17 **Spinal Manipulation.** See Section 10.2.
- 10.18 **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.
- 10.19 **Transplant Services.** Transplant services are limited to AvMed's In-Network Center of Excellence facilities located within the State of Florida. Transportation costs for a companion to accompany the Member (or two companions when the patient is a minor) are covered only if the Member 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.
- 10.20 **Ventilator Dependent Care** is limited to a lifetime maximum of 100 calendar days.

## **XI. EXCLUSIONS FROM COVERED SERVICES**

This Contract expressly excludes expenses for the following services. These Exclusions are in addition to any Exclusions specified in Part IX. COVERED SERVICE CATEGORIES and any Limitations specified in Part X. LIMITATIONS OF COVERED 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 service categories described in Part VIII. COVERED BENEFITS AND SERVICES and any amendments attached hereto, unless such services are specifically required to be covered by applicable law;
- c. services provided by a Physician or other Health Care Provider related to you by blood or marriage;
- d. services beyond the scope of practice authorized for a Health Professional under applicable state law;
- e. services which are not Medically Necessary as defined in this Contract and as determined by AvMed. The ordering of a service by a Health Care Provider does not in itself make such service Medically Necessary or a Covered Service;
- f. services rendered at no charge;
- g. services to diagnose or treat any Condition which initially occurred or resulted from you being under the influence of alcoholic beverages, 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 shall 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:

- i. medical care connected with Armed Forces service (for both sickness and injury); services received at military or government facilities; services received to treat an injury arising out of your service in the Armed Forces, Reserves or National Guard; or
- ii. 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 motor vehicle insurance (PIP) or supplemental insurance plans) and the details of such coverage;
- k. treatment, services or supplies received for injury or illness arising out of, or in the course of, employment for wage or profit, provided the Member is covered under or could be covered under any Worker's Compensation Act, Occupational Disease Act, or similar act or law, unless the Member is self-employed.

### **Additional Exclusions.**

- 11.2 **Aids or devices that assist with nonverbal communications**, including communication boards, pre-recorded speech devices, laptop computers, desktop computers, personal digital assistants, Braille typewriters, visual alert systems for the deaf and memory books.
- 11.3 **Anesthesia administration services** when performed by an operating Physician, or the Physician's partner, or associate.
- 11.4 **Assisted reproductive therapy** (infertility), including infertility evaluation, testing, diagnosis and treatment, including 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.
- 11.5 **Autopsy or postmortem examinations**, 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 **Behavioral Health Services**. Services for marriage or pre-marital counseling; services for court-ordered care or testing including any care or testing required as a condition of parole or probation; services for testing of aptitude, ability, intelligence or interest; services for testing and evaluation for the purpose of maintaining employment; services for cognitive remediation; services for educational purposes; and inpatient confinements that are primarily intended as a change of environment.
- 11.8 **Breast reduction or augmentation surgery** except as required for the comprehensive treatment of breast cancer.
- 11.9 **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.

- 11.10 **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).
- 11.11 **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 as a result of cosmetic surgical or non-surgical procedures are excluded.
- 11.12 **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.
- 11.13 **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.
- 11.14 **Dental Care for Members over age 19**, except as described in Section 9.11, 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.
- 11.15 **Diagnostic 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.
- 11.16 **Dialysis services** received from Out-of-Network Providers.
- 11.17 **Durable Medical Equipment (DME)** items that are not covered include:
- a. 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;
  - b. 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;
  - c. 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;
  - d. Electric or powered scooters; non-standard customized wheelchairs, motorized or manual;
  - e. Fixtures to real property, including ceiling lifts and wheelchair ramps;
  - f. Car/van modifications;
  - g. Air quality items: air conditioners, room humidifiers, vaporizers, air purifiers and electrostatic machines;
  - h. Blood/injection related items: blood pressure cuffs, centrifuges, nova pens and needleless injectors;

- i. 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.
  - j. The replacement of DME solely because it is old or used is excluded.
- 11.18 **Emergency Facility Services for Non-Emergency Purposes.** See Sections 2.26, 2.28 and 9.20.
- 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** are excluded except as otherwise covered under the Bone Marrow Transplant provision of Section 9.50.
- 11.21 **Eye Care for Members Over Age 19.**
- a. Eye care, including:
    - i. services to diagnose or treat vision problems which are not a direct consequence of trauma or prior ophthalmic surgery;
    - ii. eye examinations; eye exercises or visual training; and
    - iii. eye glasses and contact lenses and their fitting.
  - b. 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.
  - c. This Exclusion does not include pediatric vision services which 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 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 Section 9.13.
- 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 dysphoria is excluded, unless a Member who is age 18 or over has a diagnosis of gender dysphoria by an AvMed Network Provider, the recommended services are deemed Medically Necessary, and all criteria under AvMed's current coverage guidelines are met. Coverage guidelines are available at [www.avmed.org](http://www.avmed.org).
- 11.25 **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.
- 11.26 **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.
- 11.27 **Hearing examinations for Members over age 19** for the purpose of determining the need for hearing correction. Pediatric hearing screenings are covered through the end of the month in which a Member turns 19.
- 11.28 **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.

- 11.29 **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.
- 11.30 **Immunizations and medications** for the purpose of foreign travel or employment.
- 11.31 **Infertility Diagnosis, Treatment and Supplies.** See Section 11.4.
- 11.32 **Mandibular and maxillary osteotomies** except when Medically Necessary to treat Conditions caused by congenital or developmental deformity, disease or injury.
- 11.33 **Medical care or surgery** not rendered by a Participating Provider, except for Emergency Medical Services and Care, or not within the benefits covered by AvMed.
- 11.34 **Medical supplies** including pre-fabricated splints, Thromboembolic/support hose and all other bandages, except as provided in Section 9.33.
- 11.35 **Non-Participating Providers.** Any treatment or service from a Non-Participating Provider, except in the case of an emergency or when specifically pre-authorized by AvMed, including Hospital care from a non-participating Attending Physician or a non-participating 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.
- 11.36 **Nutritional therapy** except as described in Sections 9.31 and 10.10.
- 11.37 **Oral surgery** except as provided under Section 9.11.
- 11.38 **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.
- 11.39 **Orthotic devices** except as provided under Section 9.33. 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 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.
- 11.40 **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 outlined in Section 9.14.
- 11.41 **Pain Management.** Inpatient rehabilitation for Pain Management is excluded.
- 11.42 **Personal comfort, hygiene or convenience items and services** deemed to be not Medically Necessary and not directly related to your 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.
- 11.43 **Physical examinations or tests that are otherwise required by a third party**, such as premarital blood tests or tests for continuing employment, education, licensing or insurance.
- 11.44 **Private Duty Nursing** care or services rendered at any location.
- 11.45 **Prosthetic Devices** except as covered under Section 9.42. Expenses for microprocessor controlled or myoelectric artificial limbs (e.g. C-legs); and expenses for cosmetic enhancements to artificial limbs are also not covered.

- 11.46 **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.
- 11.47 **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.
- 11.48 **Reversal of voluntary surgically-induced sterility** including the reversal of tubal ligations and vasectomies.
- 11.49 **Sexual Dysfunction.** All medications, devices and other forms of treatment related to a diagnosis of sexual dysfunction, regardless of etiology.
- 11.50 **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.
- 11.51 **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.
- 11.52 **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.
- 11.53 **Temporomandibular Joint (TMJ) Dysfunction.** Services related to the diagnosis/treatment of TMJ except when Medically Necessary; all dental treatment for TMJ.
- 11.54 **Termination of pregnancy** unless deemed Medically Necessary, subject to applicable state and federal laws.
- 11.55 **Training and educational programs or materials,** including programs or materials for Pain Management and vocational rehabilitation, except as provided under Section 9.13.
- 11.56 **Transplant Services.** Expenses for the following are excluded:
- transplant procedures excluded under this Contract (e.g., Experimental or Investigational transplant procedures);
  - transplant procedures involving the transplantation or implantation of any non-human organ or tissue;
  - transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by AvMed;
  - transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ;
  - any organ, tissue, marrow, or stem cells which is/are sold rather than donated;
  - 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;
  - 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 Section 10.20;
  - 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.
- 11.57 **Transportation** to or from a provider, except as described in Sections 9.2 and 10.20.
- 11.58 **Travel or vacation expenses** including expenses for ambulance services to and from a Physician or Hospital except in accordance with Section 9.2, even if prescribed or ordered by a provider.
- 11.59 **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 Section 13.3d.
- 11.60 **Ventilator Dependent Care**, except as provided in Section 10.21 for 100 days lifetime maximum benefit.
- 11.61 **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.
- 11.62 **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 in Section 9.31, and exercise programs or equipment, whether or not a part of a treatment plan for a Condition.
- 11.63 **Wigs** or cranial prosthesis.
- 11.64 **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 required to 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 shall 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 shall not cover the balance of any costs remaining after the program has paid.

## **XII. PHARMACY MEDICATION BENEFITS**

- 12.1 **Pharmacy Benefits Definitions.** For 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 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. However, if the prescribing Physician or other participating Health Professional authorized to prescribe medications within the scope of his or her license indicates on the prescription 'Brand Medically Necessary' or 'dispense as written' for a medication for which

there is a Generic equivalent, the Brand Medication shall be dispensed for the applicable non-preferred brand cost-sharing amount only.

- c. **Dental-specific Medication** is medication used for dental-specific purposes including fluoride medications and medications packaged and labeled for dental-specific purposes.
- d. **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.
- e. **Maintenance Medication** is a medication that has been approved by the FDA, for which the duration of therapy can reasonably be expected to exceed one year, as determined by the Pharmacy Benefits Manager.
- f. **Participating 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 a Participating Pharmacy. Except for emergencies, covered Prescription Medications must be obtained at Participating Pharmacies.
- g. **Specialty Medications** are high cost medications that are self-administered by Members. These medications may be limited in distribution to participating 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 AvMed Participating 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 Participating 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 Participating 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 AvMed Participating 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 choose a Brand Medication when a Generic equivalent is available); or if the prescribing Physician indicates 'Brand Medically Necessary' or 'dispense as written' on the prescription for a medication for which there is a Generic equivalent, the applicable non-preferred

brand cost-sharing amount) shown in your Schedule of Benefits. Your Physician should submit prescriptions for Specialty Medications to AvMed's participating 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 Participating 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 **Pharmacy Benefits Disclaimer.** Filling a prescription at a pharmacy is not a Claim for benefits and is not subject to the Claims and Appeals procedures under the Employee Retirement Income Security Act of 1974 (ERISA). 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 **Pharmacy 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 *Florida Statute*) (See Part XI. EXCLUSIONS FROM COVERED 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 not included on AvMed's Formulary List** (See Part II. DEFINITIONS);
  - j. **Medications or devices** for the diagnosis or treatment of sexual dysfunction;
  - k. **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 the current recommendations of the United States Preventive Services Task Force, and accompanied by a prescription from your Attending Physician; **Nutritional supplements** except as described as covered in this Contract (See Section 9.31);
  - l. **Prescription and non-prescription appetite suppressants** and products for the purpose of weight loss;
  - m. **Prescription and non-prescription vitamins** and minerals except prenatal vitamins; and
  - n. **Replacement Prescription Drug** products resulting from a lost, stolen, expired, broken or destroyed prescription order or refill.

### **XIII. REVIEW PROCEDURES/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 phone. 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. AvMed may establish procedures for determining whether an individual is authorized to act on behalf of a Member.

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 365 days 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.

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

AvMed Member Engagement  
P.O. Box 569008  
Miami, Florida 33256-9906  
Telephone: 1-800-376-6651  
Fax: (305) 671-4736

b. AvMed will acknowledge and investigate the Grievance and provide a written response advising of the disposition within 60 days after receipt of the Grievance.

c. If you are not satisfied with AvMed's final decision, you may file a written Grievance with the Department of Financial Services (DFS) within 365 days of receipt of AvMed's final decision letter. You also have the right to contact DFS at any time to inform them of an unresolved Grievance. DFS may be contacted at the address below:

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

13.3 **Claims for Benefits.** All Claims for benefits will be deemed to have been filed on the date received by AvMed. If a Claim is an Urgent Care or Pre-Service Claim, a Health Professional with knowledge of the Member's Condition shall 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.

- 1) AvMed shall notify the Claimant of the benefit determination with respect to a Pre-Service Claim not later than 15 days after receipt of the Claim.
- 2) AvMed may extend this period one time for up to 15 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.
  - a) If such an extension is necessary because the Claimant failed to submit the information required to decide the Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice to provide the specified information.
  - b) In the case of a failure by a Claimant to follow AvMed's procedures for filing a Pre-Service Claim, the Claimant shall be notified of the failure and the proper procedures to be followed, not later than five days following such failure.
  - c) AvMed's period for making the benefit determination shall 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.
- 3) If the Claimant fails to supply the requested information within the 45-day period, the Claim shall 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 365 days of receiving the Adverse Benefit Determination.
  - 1) AvMed shall notify the Claimant of its determination on review not later than 30 days after AvMed receives the Claimant's request. An appeal of an Adverse Benefit Determination with respect to a Pre-Service Claim may be submitted to:
    - AvMed Member Relations
    - P.O. Box 749
    - Gainesville, Florida 32627
    - Telephone: 1-800-376-6651
    - Fax: (352) 337-8794
- b. Urgent Care Claims.
  - i. Initial Claim. Generally, the determination of whether a Claim is an Urgent Care Claim shall 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 shall be deemed urgent.
    - 1) AvMed shall notify the Claimant of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Urgent Care Claim, unless the Claimant fails to provide sufficient information to determine whether or to what extent benefits are covered or payable under this Contract.
    - 2) If such information is not provided, AvMed shall notify the Claimant not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The Claimant shall be afforded not less than 48 hours to provide the specified information.
      - a) AvMed shall notify the Claimant of the benefit determination no later than 48 hours after the earlier of:
        - i) AvMed's receipt of the specified information; or
        - ii) the end of the period afforded the Claimant to provide the specified additional information.
      - b) If the Claimant fails to supply the specified information within the 48-hour period, the Claim shall 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 shall 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 365 days of receiving the Adverse Benefit Determination.
    - 1) AvMed shall notify the Claimant of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request. An appeal of an Adverse Benefit Determination with respect to an Urgent Care Claim may be submitted to AvMed's Member Relations Department at the address listed in Section 13.3a.ii.
- c. Concurrent Care Claims.
  - i. In the event a Concurrent Care Claim results in an Adverse Benefit Determination AvMed shall 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 shall be decided as soon as possible, taking into account the medical exigencies, and AvMed shall 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, shall be made in accordance with Sections 13.4 through 13.7.

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 such a Claim will be 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 and Hawaii, the information must be translated into English.

- a) The place of service and the date of service;
- b) A description of the services including any applicable procedure codes;
- c) The diagnosis including any applicable diagnosis codes;
- d) The provider's name and address;
- e) The amount actually charged by the provider and a copy of the paid receipts;
- f) The name of the individual who received the services; and
- g) The Member's name and Member ID number as they appear on the Member Identification Card.

- 2) AvMed shall notify the Claimant of the benefit determination not later than 30 days after receipt of the Post-Service Claim.

- 3) AvMed may extend this period one time for up to 15 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 submit the information required to decide the Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice to provide the specified information.
- b) AvMed's period for making the benefit determination shall 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.

- 4) If the Claimant fails to supply the requested information within the 45-day period, the Claim shall 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 365 days of receiving the Adverse Benefit Determination.

- 1) AvMed shall notify the Claimant of the determination on review not later than 60 days after receipt of the Claimant's request. An appeal of an Adverse Benefit Determination with respect to a Post-Service Claim may be submitted to AvMed's Member Relations Department, at the address listed in Section 13.3a.ii.

**13.4 Manner and Content of Initial Claims Determination Notification.** AvMed shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth the following, 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 determination is based;

- c. 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;
- d. a description of AvMed's review procedures and the applicable time limits;
- e. in the case of an Adverse Benefit Determination involving an Urgent Care Claim, a description of the expedited review process applicable to such Claim;
- f. any internal rule, guideline, protocol or other similar criterion relied upon in making the Adverse Benefit Determination; or a statement that such rule, guideline, protocol or other similar criterion was relied upon and that a copy shall be provided free of charge to the Claimant upon request;
- g. 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 shall be provided free of charge upon request.

**13.5 Review Procedure upon Appeal.** AvMed's appeal procedures shall include the following substantive procedures and safeguards:

- a. Claimants may submit written comments, documents, records and other information relating to a Claim.
- b. Upon request and free of charge, Claimants shall 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 appeal shall take into account all comments, documents, records and other information the Claimant submitted relating to the Claim, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
- d. The appeal shall 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 shall 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 shall consult with a Health Professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
- f. The appeal shall 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 appeal shall provide that the Health Professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
- h. In the case of an Urgent Care Claim, there shall be an expedited review process 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, shall 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 shall 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 shall 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 such was relied upon and that a copy shall 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 Contract to the Member's medical circumstances; or a statement that such explanation shall 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 120 days 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 as soon as administratively possible, but not later than 72 hours. The external reviewer's recommendation will be binding. The external reviewer will notify the Claimant of its decision in writing, and the Plan will take action as appropriate to comply with such recommendation. For detailed information about the external review process, please contact AvMed's Member Engagement Center.

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

- a. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your Claim by an independent third party, who will review the denial and issue a final decision. You may contact AvMed's Member Engagement Center at 1-800-376-6651 with any questions on your rights to external review. Please understand that if you want to be informed about the legal remedies that may be available to you and whether they are a better option for you than seeking independent external review, you should consult a lawyer of your choice. AvMed cannot provide you with legal advice. We can only explain the procedures for obtaining independent external review.
- b. If this Plan is subject to ERISA, please see the Addendum to this Group Medical and Hospital Service Contract. You also have the right to seek such legal remedies as may be available to you under ERISA Section 502 or state law.

#### **XIV. COORDINATION OF BENEFITS**

Coordination of Benefits (COB) is a limitation of coverage and benefits to be provided by AvMed. This provision is required by and subject to applicable federal and Florida law concerning coordination of health care benefits and will be modified to the extent necessary to enable us to comply with such laws. COB determines the manner in which expenses will be paid when you are covered under more than one health plan, program, or policy providing benefits for Health Care Services. COB is designed to avoid the costly duplication of payment for Covered Services.

14.1 **Items Subject to COB.** 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:

- a. any group or non-group health insurance, or HMO plan;

- b. any other plan, program or insurance policy, including an automobile PIP insurance policy or medical payment coverage which the law permits us to coordinate benefits with;
- c. Medicare, Medicaid and other government programs; and
- d. to the extent permitted by law, any other government sponsored health insurance program.

14.2 **Member's Responsibilities to Avoid Duplication of Coverage.** It is your responsibility to provide us and your Physician with information concerning any duplication of coverage under any other health plan, program, or policy you or your Covered Dependents may have. This means you must notify us in writing if you have other applicable coverage. You may be requested to provide this information at the time you apply for this Contract or at enrollment, by written correspondence annually thereafter or in connection with a specific Health Care Service you receive. **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 denied Claims.**

14.3 **Primary Payer.** 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 we are primary, we will pay for Covered Services without regard to coverage under other plans. 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 a Participating Provider, 'total reasonable expenses' shall 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.

14.4 **Payment in Excess of Contracted Amount.** 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.

14.5 **Determination of Order of Benefits.** The following rules shall be used to establish the order in which benefits under the respective plans will be determined.

- a. When we cover you as a Covered Dependent and another plan covers you as other than a dependent, we will be secondary.
- b. When we cover a dependent child whose parents are not separated or divorced:
  - i. the plan of the parent whose birthday, excluding year of birth, falls earlier in the year will be primary; or
  - ii. if both parents have the same birthday, excluding year of birth, and the other plan has covered one of the parents longer than us, we will be secondary.
- c. When we cover a dependent child whose parents are separated or divorced:
  - i. if a parent with sole parental responsibility is not remarried, the plan of the parent with custody is primary;
  - ii. 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
  - iii. 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.
- d. When we cover a dependent child and the dependent child is also covered under another plan:
  - i. the plan of the parent who is neither laid off nor retired will be primary; or
  - ii. if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.
- e. If you have continuation of coverage under COBRA or the Florida Health Insurance Coverage Continuation Act (FHICCA or 'mini COBRA'), COBRA or FHICCA would be primary.

- f. When paragraphs a. through e. above do not establish an order of benefits, the plan which has covered you the longest shall be primary, unless you are age 65 or older and covered under Medicare Parts A and B. In that case, the Medicare Secondary Payer provisions will determine which coverage is primary.
  - g. 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.
  - 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.
- 14.6 **Facility of Payment.** Whenever payments which are payable by us under this Contract are made by any other person, plan, or organization, we will have the right, exercisable alone and in our sole discretion, to pay over to any such person, plan, or organization making such other payments, any amounts we determine to be required in order to satisfy our coverage obligations hereunder. Amounts so paid shall be deemed to be paid under this Contract and, to the extent of such payments, we will be fully discharged from liability.
- 14.7 **Non-Duplication of Coverage.** The benefits under this Contract shall not duplicate any benefits to which you or your Covered Dependents are entitled to, or eligible for, under any insurance policy (except as specifically provided in this Part XIV, government programs (e.g., Medicare, Medicaid, Veterans Administration) or Workers' Compensation to the extent allowed by law, or under any extension of benefits of coverage under a prior plan or program which may be provided or required by law.

## **XV. SUBROGATION AND RIGHT OF RECOVERY**

- 15.1 **AvMed's Right of Subrogation and Recovery.** If AvMed arranges 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 benefits provided by AvMed on behalf of the Member that are associated with the injury or illness for which another party is or may be responsible. 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 **Member Specifically Acknowledges 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 shall 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 **Member Specifically Acknowledges 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 shall 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 Subscribing Group.** Neither Subscribing Group nor its agents, servants or employees, nor any Member is the agent or representative of AvMed, and none of them shall be liable for any acts or omissions of AvMed, its agents or employees, or of a participating Hospital, or a Participating Physician, or any other person or organization with which AvMed has made or hereafter shall make arrangements for the performance of services under this Contract.
- 16.2 **Indemnity of Members.** Members shall not be liable to AvMed or Participating Providers except as specifically set forth herein, provided all procedures set forth herein are followed.
- 16.3 **Indemnity of AvMed.** Neither AvMed nor its agents, servants or employees is the agent or representative of the Subscribing Group, and none of them shall be liable for any acts or omissions of Subscribing Group, its agents or employees or any other person representing or acting on behalf of Subscribing Group.
- 16.4 **Relationship of AvMed and Participating 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 shall be deemed not to be a Health Care Provider with respect to any services performed or rendered by any such independent contractors. Participating Providers maintain the Physician/patient relationship with Members and are solely responsible for all Health Care Services which Participating Providers render to Members. Therefore, AvMed shall 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 shall not be vicariously liable for any negligent act or omission of any of these independent Health Professionals who treat a Member of AvMed.
- 16.5 **AvMed and Health Care Providers.** Neither AvMed nor any of its officers, directors or employees provides Health Care Services to you. Rather, we are engaged in making coverage and benefit decisions

under this Contract. By accepting our coverage and benefits, you agree that making such coverage and benefit decisions does not constitute the rendering of Health Care Services and that Health Care Providers rendering those services are not our employees or agents. In this regard, we hereby expressly disclaim any agency relationship, actual or implied, with any Health Care Provider.

- 16.6 **AvMed's Role.** We do not, by virtue of making coverage, benefit, and payment decisions, exercise any control or direction over the medical judgment or clinical decisions of any Health Care Provider. Any decisions we make concerning appropriateness of setting, or whether any service is Medically Necessary, shall be deemed to be made solely for purposes of determining whether such services are covered, and not for purposes of recommending any treatment or non-treatment. In addition, we assume no liability for any loss or damage arising as a result of acts or omissions of any Health Care Provider.
- 16.7 **Member's Ability to Refuse Procedures and Treatment and Consequences Therein.** Certain Members may, for personal reasons, refuse to accept procedures or treatment recommended by Participating 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 Participating Physician and if, in the judgment of the Participating Physician, no professionally acceptable alternative exists or if an alternative treatment does exist but is not recommended by the Participating Physician, the Participating Physician shall advise the Member of its determination.

## XVII. GENERAL PROVISIONS

- 17.1 **Amendment.** The terms of coverage and benefits to be provided by us may be amended annually on this Contract's anniversary date, without your consent or the consent of any other person, upon 45 days prior written notice to the Subscribing Group. In the event the amendment is unacceptable to the Subscribing Group, the Subscribing Group may terminate this Contract upon at least 15 days prior written notice to us. Any such amendment will be without prejudice to Claims filed with us and related to Covered Services prior to the date of such amendment. No agent or other person, except a duly authorized officer of AvMed, has the authority to modify the terms of this Contract, or to bind us in any manner not expressly described herein, including the making of any promise or representation, or by giving or receiving any information. The terms of coverage and benefits to be provided by us may not be amended by the Subscriber unless such amendment is evidenced in writing and signed by a duly authorized officer of AvMed.
- 17.2 **Assignment and Delegation.** Your rights and obligations arising hereunder may not be assigned, delegated or otherwise transferred by you without our written consent. We may assign our rights and coverage or benefit obligations to our successor in interest or an affiliated entity without your consent at any time. Any assignment, delegation, or transfer made in violation of this provision shall be void.
- 17.3 **Circumstances Not Reasonably Within the Control of AvMed.** In the event of circumstances not reasonably within the control of AvMed, including major disasters and under such circumstances as complete or partial destruction of facilities, an act of God, war, riot, civil insurrection, disability of a significant part of a Hospital or participating 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, Participating Providers, nor any Physician shall have any liability or obligation on account of such delay or failure to provide services; however, AvMed shall make a good faith effort to arrange for the timely provision of Covered Services during such event.
- 17.4 **Clerical Errors.** Clerical errors shall neither deprive any individual Member of any benefits or coverage provided under this Group Contract, nor shall such errors act as authorization of benefits or coverage for the Member that is not otherwise validly in force.
- 17.5 **Compliance with State and Federal Laws and Regulations.** The terms of coverage and benefits to be provided by us under this Contract shall be deemed to have been modified by the parties, and shall be interpreted, so as to comply with applicable state or federal laws and regulations dealing with rates, benefits, eligibility, enrollment, termination, conversion, or other rights and duties of you, or AvMed.

- 17.6 **Confidentiality.**
- a. Except as otherwise specifically provided herein, and except as may be required in order for us to administer coverage and benefits, specific medical information concerning you, received by providers, shall 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, shall not be subject to this provision.
  - b. Our arrangements with a provider may require that we release certain Claims and medical information about persons covered under this Contract to that provider even if treatment has not been sought by or through that provider. By accepting coverage, you hereby authorize us to release to providers Claims information, including related medical information, pertaining to you in order for any such provider to evaluate your financial responsibility under this Contract.
- 17.7 **Contracting Parties.** By executing this Contract, Subscribing Group and AvMed agree to make the Health Care Services and Hospital services specified herein available to persons who are eligible under the provisions of Part III. ELIGIBILITY FOR COVERAGE. Subscribing Group hereby represents that it has met the non-discrimination testing requirements under U.S. Code Section 105(h). The delivery of benefits and services covered in this Contract shall be subject to the provisions, Limitations and Exclusions set forth herein and any amendments, modifications and Contract termination provisions specified herein and by the mutual agreement between AvMed and Subscribing Group, without the consent or concurrence of the Members. By electing or accepting Health Care Services and Hospital or other benefits hereunder, all Members legally capable of contracting and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions hereof.
- 17.8 **Contract Review by Subscribing Group.** The Subscribing Group may, if this Contract is not satisfactory for any reason, return this Contract within three days after receipt and receive a full refund of the deposit paid, if any, unless the services of AvMed were utilized during the three days. If this Contract is not returned within three days after receipt, then this Contract shall be deemed to have been accepted.
- 17.9 **Cooperation Required of You and Your Covered Dependents.** You must cooperate with us, and must execute and submit to us any consents, releases, assignments, and other documents we may request in order to administer, and exercise our rights hereunder. Failure to do so may result in the denial of Claims and will constitute grounds for termination for cause by us (see Part V. TERMINATION).
- 17.10 **Entire Agreement.** This Contract, including the application for coverage and any enrollment forms, sets forth the exclusive and entire understanding and agreement between you and AvMed and shall be binding upon Subscribing Group, all Members, AvMed, and any of their subsidiaries, affiliates, successors, heirs, and permitted assignees. All prior negotiations, agreements, and understandings are superseded hereby.
- 17.11 **Evidence of Coverage.** You have been provided with this Contract as evidence of coverage.
- 17.12 **ERISA.** When this Contract is purchased by the Subscribing Group to provide benefits under a welfare plan governed by ERISA, AvMed shall be considered a fiduciary to the extent that it performs any discretionary functions on behalf of the Plan. If a Member has questions about the group's welfare plan, the Member should contact the Subscribing Group.
- 17.13 **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](http://www.avmed.org).
- 17.14 **Governing Law.** The terms of coverage and benefits to be provided hereunder, and the rights of the parties hereunder, shall be construed in accordance with the laws of the State of Florida and the United States, when applicable.

- 17.15 **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 1-800-376-6651 or visit AvMed's website at [www.avmed.org](http://www.avmed.org). Member Identification Cards are AvMed's property and, upon request, shall be returned to AvMed within 30 days of the termination of your coverage.
- 17.16 **Membership Application.** Members or applicants for membership shall complete and submit to AvMed such applications or other forms or statements as AvMed may reasonably request. If a Member or applicant fails to provide accurate information which AvMed deems material then, upon ten days written notice, AvMed may deny membership to such individual. Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of Claim or an application containing any false, incomplete or misleading information is guilty of a felony, punishable as provided by *Florida Statutes*.
- 17.17 **Misrepresentation of Material Fact by Party Applying for Coverage.** Time limit on certain defenses: Fraudulent or intentional misrepresentation of material facts made by the applicant, Subscriber, or Covered Dependents which are discovered by AvMed within two years of the issue date of the Contract may prevent payment of benefits under this Contract and may void this Contract for the individual making the misrepresentation or fraudulent statement. Fraudulent misstatements discovered by AvMed at any time, may result in this Contract being voided or Claims being denied for the individual about whom the fraudulent misstatement is made.
- 17.18 **Misstatement of Age, Residence or Tobacco Use.** If any written information has been misstated by you, upon 30 days notice from AvMed, the Premium amount owed under this Contract will be what the Premium would have been had the correct information been provided to AvMed. If such misstatement causes us to accept Premiums for a time period during which we would not have accepted Premiums if the correct information had been stated, our only liability will be the return of any unearned Premium. We will not provide any coverage for that time period. This right is in addition to any other rights we may have under this Contract and applicable laws.
- 17.19 **Modification of AvMed Provider Network and Participation Status.** The AvMed Achieve 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 a Participating Provider at the time the Health Care Service is rendered.
- 17.20 **Non-Waiver of Defaults.** 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.
- 17.21 **Notices.** Any notice required or permitted hereunder will be deemed given if hand delivered or if mailed by the United States Postal Service, postage prepaid, and addressed as listed below. Such notice will be deemed effective as of the date delivered or so deposited in the mail.
- a. If to us:  
To the address printed on the AvMed Identification Card.
  - b. If to you:  
To the latest address provided by you according to our records or to the Member's latest address on enrollment forms actually delivered to us.
  - c. If to Subscribing Group:  
To the address provided in the Group Master Application.

- 17.22 **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.
- 17.23 **Premium Tax/Surcharge.** If any government entity shall impose a Premium tax or surcharge, then upon 30 days notice from AvMed, the sums due from the Subscribing Group under the terms of this Contract shall be increased by the amount of such Premium tax or surcharge.
- 17.24 **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.
- 17.25 **Rate Letter.** The term 'Rate Letter' refers to a compilation of documents which constitute AvMed's formal notice to the Subscribing Group of: (i) the Premium rates applicable to the Subscribing Group, (ii) the conditions under which the rates are valid, (iii) the Premium payment terms and due dates, and (iv) the additional charge which will apply to all late Premium payments. AvMed reserves the right to adjust (re-rate) the Premium rates to account for material changes in group size or in the data supplied by the Subscribing Group to AvMed.
- 17.26 **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.
- 17.27 **Third Party Beneficiary.** This Contract was issued by AvMed to the Subscriber, and was entered into solely and specifically for the benefit of AvMed and the Subscriber. The terms and provisions of the Contract shall be binding solely upon, and inure solely to the benefit of, AvMed and the Subscriber, and no other person shall have any rights, interest or claims hereunder, or be entitled to sue for a breach hereof as a third-party beneficiary or otherwise. AvMed and the Subscriber hereby specifically express their intent that Health Care Providers that have not entered into contracts with AvMed to render the professional Health Care Services set forth herein shall not be third-party beneficiaries under this Contract.

## **XVIII. PEDIATRIC DENTAL BENEFITS**

- 18.1 **Provision of Pediatric Dental Services and Benefits.** AvMed has arranged for the delivery of pediatric dental services and Benefits for Covered Dependent children from birth through the end of the Calendar Year in which they turn 19, to be administered by Delta Dental Insurance Company (hereinafter referred to as "Delta Dental").
- a. **Member Identification Number.** Please provide the Enrollee's AvMed Member identification ("ID") number to your Dental Provider whenever you receive pediatric dental services. The Member ID number should be included on all claims submitted for payment. Dental ID cards are not required, but if you wish to have one you may obtain one by visiting Delta's website at [www.deltadentalins.com](http://www.deltadentalins.com).
  - b. **Customer Service.** For more information about the pediatric dental services and Benefits, please visit [www.deltadentalins.com](http://www.deltadentalins.com), or call Delta Dental's Customer Service Center. A Customer Service representative can answer questions you may have about obtaining dental care, help you locate a Dental Provider, explain Benefits, check the status of a claim and assist you in filing a claim. You can access the automated information line at 800-521-2651 to obtain information about your eligibility, Benefits or claim status or to speak to a dental Customer Service representative for assistance.
- 18.2 **Dental Plan Definitions.** The following are words that have special or technical meanings under the pediatric dental services and Benefits described in this Part XVIII, and made available under this Contract.
- a. **Accepted Fee** means the amount the attending Dental Provider agrees to accept as payment in full for services rendered.
  - b. **Benefits** mean the amounts that will be paid for covered pediatric dental services.

- c. Claim Form means the standard form used to file a dental claim, request a dental Pre-Treatment Estimate, or request Prior Authorization.
- d. Contract Benefit Level is the percentage of the Maximum Contract Allowance paid under the dental plan.
- e. Dental Deductible means the dollar amount that an Enrollee must satisfy for certain covered dental services before dental Benefits are paid.
- f. Dental Out-of-Pocket Maximum means the maximum amount that a Member will pay during a Calendar Year for Pediatric dental Benefits from a PPO Provider before Delta Dental begins to pay 100% of the PPO Contracted Fee. Coinsurance and other cost-sharing, including balance billed amounts, will continue to apply for covered Dental Services from a Dental Premier and Non-Participating Providers even after the Out-of-Pocket Maximum has been met.
- g. Dental Provider means a person licensed to practice dentistry when and where services are performed and may be referred to as a "PPO Provider", a "Premier Provider" or a "Non-Delta Dental Provider". A Dental Provider shall also include a dental partnership, dental professional corporation or dental clinic.
- h. Eligible Pediatric Individual means a Covered Dependent child under age 20 who is eligible for the pediatric dental Benefits described herein.
- i. Enrollee means a Covered Dependent child who is an Eligible Pediatric Individual ("Pediatric Enrollee") enrolled to receive Benefits under the dental plan.
- j. Enrollee Pays means a Member's financial obligation for services, calculated as the difference between the amount shown as the 'Accepted Fee' and the portion shown as 'Delta Dental Pays' on the claims statement when a claim is processed.
- k. Essential Health Benefits ("Pediatric Benefits"). Essential Health Benefits are certain pediatric oral services that are required to be included under the Affordable Care Act. The services considered to be Essential Health Benefits are determined by state and federal agencies and are available for Eligible Pediatric Individuals.
- l. Maximum Contract Allowance is the reimbursement under the Enrollee's Plan against which the Dental Provider payment and the Member's financial obligation are calculated. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided:
  - i. by a PPO Provider, is the lesser of the Provider's Submitted Fee or the PPO Provider's Contracted Fee; or
  - ii. by a Premier Provider, is the lesser of the Provider's Submitted Fee or the PPO Provider's Contracted Fee for a PPO Provider in the same geographic area; or
  - iii. by a Non-Delta Dental Provider, is the lesser of the Provider's Submitted Fee or the Dental PPO Provider's Contracted Fee for a PPO Provider in the same geographic area.
- m. Non-Delta Dental Provider means a Provider who is not a Dental PPO or Dental Premier Provider and who is not contractually bound to abide by the dental plan administrative guidelines.
- n. PPO Contracted Fee is the fee for each Single Procedure that a PPO Provider has contractually agreed to accept as payment in full for covered services.
- o. PPO Provider means a Dental Provider who contracts with the dental plan and agrees to accept the PPO Contracted Fee as payment in full for services provided under the dental plan.
- p. Premier Contracted Fee is the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for covered services.
- q. Premier Provider means a Dental Provider who contracts with the dental plan, and agrees to accept the Premier Contracted Fee as payment in full for services provided under the dental plan.
- r. Pre-Treatment Estimate is an estimate of the allowable Benefits under this dental plan for the services proposed, assuming the person is an eligible Enrollee.
- s. Procedure Code is the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.
- t. Single Procedure means a dental procedure that is assigned a separate Procedure Code.

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

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

a. Benefits, Limitations and Exclusions.

- i. Dental Benefits are payable only for covered services. The dental plan covers several categories of Benefits when a Dental Provider furnishes the services and when they are necessary and within the standards of generally accepted dental practice. Claims shall be processed in accordance with the dental plan standard processing policies. Dentists (dental consultants) may be used to review treatment plans, diagnostic materials or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis. If you receive dental services from a Dental Provider outside the state of Florida, the Provider will be paid according to the dental network payment provisions for said state according to the terms of the Contract.
- ii. If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the Benefit payable. Even if the Dental Provider bills separately for the primary procedure and each of its component parts, the total Benefit payable for all related charges will be limited to the maximum Benefit payable for the primary procedure.

b. Enrollee Coinsurance.

- i. The dental plan will pay a percentage of the Maximum Contract Allowance for covered services, subject to certain Limitations, and you are responsible for paying the balance. What you pay is called the enrollee coinsurance ("Enrollee Coinsurance") and is part of your out-of-pocket cost. You may have to satisfy a Deductible before dental Benefits are paid. You pay the Enrollee Coinsurance even after a Deductible has been met.
- ii. The amount of your Enrollee Coinsurance will depend on the type of service and the Dental Provider furnishing the service (see Section 18.4 Selecting Your Dental Provider.) Providers are required to collect Enrollee Coinsurance for covered services. If the Provider discounts, waives or rebates any portion of the Enrollee Coinsurance to you, the dental plan will be obligated to provide as Benefits only the applicable percentages of the Provider's fees or allowances reduced by the amount of the fees or allowances that is discounted, waived or rebated.
- iii. It is to your advantage to select PPO Providers because they have agreed to accept the Maximum Contract Allowance as payment in full for covered services, which typically results in lower out-of-pocket costs for you. Please refer to Section 18.4 Selecting Your Dental Provider., for more information.

c. Pre-Treatment Estimates.

- i. Pre-Treatment Estimate requests are not required; however, your Provider may file a Claim Form before beginning treatment, showing the services to be provided to you. A Pre-Treatment Estimate will estimate the amount of Benefits payable under the dental plan for the listed services. By asking your Dental Provider for a Pre-Treatment Estimate before the Enrollee receives any prescribed treatment, you will have an estimate up front of what your dental Benefits will pay and the difference you will need to pay. The Benefits will be processed according to the terms of the dental plan when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days or until an earlier occurrence of any one of the following events:
  - 1) the date this Contract terminates;
  - 2) the date the Enrollee's coverage ends; or
  - 3) the date the Dental Provider's agreement with the dental plan ends.
- ii. A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount the dental plan will pay if you are covered and meet all the requirements of the plan at the time the planned treatment is completed and may not take into account any Deductibles, so please remember to figure in your Deductible if necessary.

d. Coordination of Benefits.

- i. Delta Dental coordinates the dental Benefits under this dental plan with your benefits under any other group or pre-paid plan or insurance plan designed to fully integrate with other plans. If this plan is the "primary" plan, Delta Dental will not reduce Benefits. If this plan is the "secondary" plan, Delta Dental may reduce Benefits so that the total benefits paid or provided by all plans do not exceed 100% of total allowable expense.
- ii. How does Delta Dental determine which Plan is the "primary" plan?
  - 1) The plan covering the Enrollee as an employee is primary over a plan covering the Enrollee as a dependent.
  - 2) The plan covering the Enrollee as an employee is primary over a plan covering the insured person as a dependent; except that if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    - a) secondary to the plan covering the insured person as a dependent; and
    - b) primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.
  - 3) Except as stated in paragraph 4), when this plan and another plan cover the same child as a dependent of different persons, called parents:
    - a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
    - b) if both parents have the same birthday, the benefits of the plan covering one parent longer are determined before those of the plan covering the other parent for a shorter period of time.
    - c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.
  - 4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody or as a dependent of the custodial parent's spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree establishing financial responsibility for the health care expenses with respect to the child, the benefits of a plan covering the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy covering the child as a dependent child.
  - 5) If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph 3).
  - 6) The benefits of a plan covering an insured person as an employee who is neither laid-off nor retired are determined before those of a plan covering that insured person as a laid-off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule 6) is ignored.
  - 7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination.
    - a) First, the benefits of a plan covering the insured person as an employee (or as that insured person's dependent).
    - b) Second, the benefits under the continuation coverage.

- c) If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule 7) is ignored.
- 8) If none of the above rules determines the order of benefits, the benefits of the plan covering an employee longer are determined before those of the plan covering that insured person for the shorter term.
- 9) When determination cannot be made in accordance with the above for Pediatric Benefits, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental only plan.

#### 18.4 **Selecting Your Dental Provider.**

- a. Free Choice of Provider. You may see any Dental Provider for your covered treatment whether the Provider is a PPO Provider, Premier Provider or a Non-Delta Dental Provider. This plan is a dental PPO plan and the greatest benefits – including out-of-pocket savings – occur when you choose a PPO Provider. To take full advantage of your Benefits, you should verify a dentist's status within the dental network before each appointment. Review this section for an explanation of the dental plan payment procedures to understand the method of payments applicable to your Dental Provider selection and how that may impact your out-of-pocket costs.
- b. Locating a PPO Provider You may access information at [www.deltadentalins.com](http://www.deltadentalins.com). You may also call Delta Dental's Customer Service Center and a representative will provide you with information regarding a Provider's network participation, specialty and office location.
- c. Choosing a PPO Provider.
  - i. The PPO plan potentially allows the greatest reduction in Enrollees' out-of-pocket expenses since this select group of Providers will provide dental Benefits at a charge that has been contractually agreed upon. Payment for covered services performed by a PPO Provider is based on the Maximum Contract Allowance.
  - ii. Costs incurred by the Pediatric Enrollee for covered services with a PPO Provider apply towards the Out-of-Pocket Maximum for pediatric dental Benefits.
- d. Choosing a Premier Provider
  - i. A Premier Provider is a participating provider under this dental plan; however, the Premier Provider has not agreed to the features of the PPO plan. The amount charged may be above that accepted by PPO Providers, and Enrollees will be responsible for balance billed amounts. Payment for covered services performed by a Premier Provider is based on the Maximum Contract Allowance, and the Enrollee may be balance billed up to the Premier Provider's Contracted Fee.
  - ii. Costs incurred by the Pediatric Enrollee with a Premier Provider do not count towards the Out-of-Pocket Maximum for Pediatric Benefits. Enrollee Coinsurance and other cost-sharing, including balance billed amounts, continue to apply when a Premier Provider is used even if the Out-of-Pocket Maximum for Pediatric Enrollees has been met.
- e. Choosing a Non-Delta Dental Provider
  - i. If a Provider is a Non-Delta Dental Provider, the amount charged to Enrollees may be above that accepted by PPO Providers, and Enrollees will be responsible for balance billed amounts. Payment for covered services performed by a Non-Delta Dental Provider is based on the Maximum Contract Allowance, and the Enrollee may be balance billed up to the Provider's Submitted Fee.
  - ii. Costs incurred by the Pediatric Enrollee with a Non-Delta Dental Provider do not count towards the Out-of-Pocket Maximum for Pediatric Benefits. Enrollee Coinsurance and other cost-sharing, including balance billed amounts, continue to apply when a Non-Delta Dental Provider is used even if the Out-of-Pocket Maximum for Pediatric Enrollees has been met.
- f. Additional Obligations of PPO Providers
  - i. The PPO Provider or Premier Provider must accept assignment of Benefits, meaning these Providers will be paid directly after satisfaction of the Deductible and Enrollee Coinsurance. The

- Enrollee does not have to pay all the dental charges while at the dental office and then submit the claim for reimbursement.
- ii. The PPO Provider or Premier Provider will complete the dental Claim Form and submit it to the dental plan for reimbursement.
  - iii. The PPO Provider will accept contracted fees as payment in full for covered services and will not balance bill if there is a difference between Submitted Fees and PPO Contracted Fees.
- g. How to Submit a Claim
- i. Claims for Benefits must be filed on a standard Claim Form that is available in most dental offices. PPO and Premier Providers will fill out and submit your claims paperwork for you. Some Non-Delta Dental Providers may also provide this service upon your request. If you receive services from a Non-Delta Dental Provider who does not provide this service, you can submit your own claim directly to the dental plan. Please refer to the section titled "Dental Claim Form" for more information.
  - ii. Your dental office should be able to assist you in filling out the Claim Form. Fill out the Claim Form completely and send it to:  
Delta Dental  
P.O. Box 1809  
Alpharetta, GA 30023-1809  
678-297-1972 fax
- h. Payment Guidelines.
- i. PPO or Premier Providers are not paid any incentive as an inducement to deny, reduce, limit or delay any appropriate service.
  - ii. If you or your Provider files a claim for services more than 12 months after the date you received the services, payment may be denied. If the services were received from a Non-Delta Dental Provider, you are still responsible for the full cost. If the payment is denied because your PPO or Premier Provider failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your PPO or Premier Provider that you were covered under this dental plan at the time you received the service, you may be responsible for the cost of that service.
  - iii. This dental coverage is arranged by AvMed and administered by Delta Dental. If Delta Dental is unable to pay a dental claim for covered services, AvMed remains responsible for payment of such claim consistent with the terms and conditions of this Contract.
  - iv. If you have any questions about any dental charges, processing policies or how your claim is paid, please contact Delta Dental.
- i. Provider Relationships.
- i. Any PPO, Premier or Non-Delta Dental Provider, including any Provider or employee associated with or employed by them, who provides dental services to an Enrollee does so as an independent contractor and shall be solely responsible for dental advice and for performance of dental services, or lack thereof, to the Enrollee.

## 18.5 Grievances and Appeals.

- a. If you have questions about any pediatric dental services received, please first discuss the matter with your Dental Provider. However, if you continue to have concerns, please call Delta Dental's Customer Service Center. You can also email questions by accessing the "Contact Us" section of the dental plan website at [www.deltadentalins.com](http://www.deltadentalins.com)
- b. Grievances.
  - i. Grievances regarding eligibility, the denial of dental services or claims, the policies, procedures, or the quality of dental services performed by the Dental Provider may be directed in writing to the dental plan or by calling toll-free at 800-521-2651.

- ii. When you write, please include the name of the Enrollee, the AvMed Member ID number and your telephone number on all correspondence. You should also include a copy of the Claim Form, claim statement or other relevant information. Your claim statement will have an explanation of the claim review and any grievance process and time limits applicable to such process.
- iii. You and your Provider will be notified if Benefits are denied for services submitted on a Claim Form, in whole or in part, based upon lack of medical necessity. Any such denial will be based upon a determination by a Provider who holds a non-restricted license in the same or an appropriate specialty that typically manages the dental condition, procedure or treatment under review. You and your Provider have at least 180 days after receiving a notice of denial to request a review in writing giving reasons why you believe the denial was wrong. Send your grievance to the address shown below:

Delta Dental  
P.O. Box 1809  
Alpharetta, GA 30023-1809  
678-297-1972 fax

- iv. Delta Dental will send you a written acknowledgment within five (5) days upon receipt of your grievance and will review and send you a decision within 30 days. The review will take into account all comments, documents, records or other information, regardless of whether such information was submitted or considered initially. If the review is of a denial based in whole or in part on lack of dental necessity, experimental treatment or clinical judgment in applying the terms of the dental Benefits there will be consultation with a dentist who has appropriate training and experience. The review will be conducted by a person who is neither the individual who made the claim denial that is subject to the review, nor the subordinate of such individual.

c. Appeals.

- i. If you believe you need further review of your dental claim, you may contact your Florida Department of Financial Services. If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA), for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under Section 502(a) of ERISA. The address of the U.S. Department of Labor is:

U.S. Department of Labor,  
Employee Benefits Security Administration (EBSA)  
200 Constitution Avenue, N.W.  
Washington, D.C. 20210.

18.6 **General Provisions.**

a. Clinical Examination.

- i. Before approving a dental claim, Delta may require information and records relating to attendance to or examination, or treatment provided to you, to administer the claim; or may have you be examined by a dental consultant when and as often as may be reasonably required during the pendency of a claim, in or near your community or residence.

b. Written Notice of Dental Claim/Proof of Loss.

- i. There must be written proof of loss within 12 months after the date of the loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give written proof in the time required, provided that the proof is filed as soon as reasonably possible. A notice of claim submitted by you, on your behalf, or on behalf of your beneficiary with information sufficient to identify you will be considered notice of claim.
- ii. Send your Notice of Claim/Proof of Loss to at the address shown below:

Delta Dental  
P.O. Box 1809

Alpharetta, GA 30023-1809  
678-297-1972 fax

c. Claim Form.

- i. Within 15 days after receiving a notice of a claim, you or your Dental Provider will be provided with a Claim Form to make claim for Benefits. To make a claim, the form should be completed and signed by the Provider who performed the services, and by the patient (or the parent or guardian if the patient is a minor), and submitted to the address above.
- ii. If a Claim Form is not sent to you or your Provider within 15 days after you or your Provider gave notice regarding a claim, the requirements for proof of loss outlined in the section "Written Notice of Claim/Proof of Loss" above will be deemed to have been complied with as long as you give written proof that explains the type and the extent of the loss that you are making a claim for, within the time established for filing proofs of loss. You may also download a Claim Form from the dental plan website at [www.deltadentalins.com](http://www.deltadentalins.com).

d. Time of Payment.

- i. Dental claims payable for any loss other than loss that is a periodic payment will be processed no later than 30 days after written proof of loss is received in the form required. You and your Provider will be notified of any additional information needed to process the claim within this 30 day period.

e. To Whom Benefits Are Paid

- i. It is not required that the service be provided by a specific dentist. Payment for services provided by a PPO or Premier Provider will be made directly to the dentist. Any other payments will be made to you unless you request in writing when filing a proof of claim that the payment be made directly to the Dental Provider providing the services. All Benefits not paid to the Provider will be payable to you or to your estate, or to an alternate recipient as directed by court order, except that if the person is a minor or otherwise not competent to give a valid release, Benefits may be payable to his or her parent, guardian or other person actually supporting him or her.

18.7 **Deductibles, Maximums, Contract Benefit Levels and Enrollee Coinsurances.**

<b>Deductibles &amp; Maximums</b>	
<b>Annual Deductible</b> Pediatric Enrollee	\$65 each Calendar Year
<b>Out-of-Pocket Maximum*</b> Pediatric Enrollee Multiple Pediatric Enrollees	\$350 each Calendar Year for only one covered Pediatric Enrollee \$700 each Calendar Year for two or more covered Pediatric Enrollees

\* Out-of-Pocket Maximum applies only to Essential Health Benefits that are provided by PPO Providers for Pediatric Enrollees. Once the amount paid by Pediatric Enrollees equals the Dental Out-of-Pocket Maximum, no further payment will be required by the Pediatric Enrollees for the remainder of the Calendar Year for covered services received from PPO Providers. Enrollee Coinsurance and other cost sharing, including balance billed amounts, will continue to apply for covered services from Premier or Non-Delta Dental Providers even after the Dental Out-of-Pocket Maximum is met.

\* If two or more Pediatric Enrollees are covered, the financial obligation for covered services received from PPO Providers is not more than the multiple-Pediatric Enrollees Dental Out-of-Pocket Maximum. However, once a Pediatric Enrollee meets the Dental Out-of-Pocket Maximum for one covered Pediatric Enrollee, that Pediatric Enrollee will have satisfied his/her Dental Out-of-Pocket Maximum. Other covered Pediatric Enrollees must continue to pay Enrollee Coinsurance for covered services received from PPO Providers until the total amount paid reaches the Dental Out-of-Pocket Maximum for multiple Pediatric Enrollees.

**Contract Benefit Levels & Enrollee Coinsurances**

Dental Service Category	PPO <sup>1</sup>	
	Dental Plan <sup>2</sup>	Enrollee <sup>2</sup>
Diagnostic and Preventive Services	100%	0%
Basic Services	50%	50%
Major Services	50%	50%
Medically Necessary Orthodontic Services (requires prior authorization)	50%	50%
Waiting Periods	No Waiting Periods	

<sup>1</sup> Reimbursement is based on PPO Contracted Fees for PPO, Premier and Non-Delta Dental Providers.

<sup>2</sup> The dental plan will pay or otherwise discharge the Contract Benefit Level according to the Maximum Contract Allowance for covered services. Note: payment is the same Contract Benefit Level for covered services performed by a PPO Provider, Premier Provider and a Non-Delta Dental Provider. However, the amount charged to Enrollees for covered services performed by a Premier Provider or Non-Delta Dental Provider may be above that accepted by PPO Providers, and Enrollees will be responsible for balance billed amounts.

### 18.8 Description of Dental Services.

a. The dental plan will pay or otherwise discharge the Contract Benefit Level shown in Section 18.7 for Essential Health Benefits when provided by a Dental Provider and when necessary and customary under generally accepted dental practice standards and for medically necessary Orthodontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health. Benefits for medically necessary orthodontics will be provided in periodic payments based on continued enrollment.

#### b. Diagnostic and Preventive Services

1.	Diagnostic:	procedures to aid the Provider in determining required dental treatment.
2.	Preventive:	cleaning (periodontal cleaning in the presence of inflamed gums is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers.
3.	Sealants:	topically applied acrylic, plastic or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.
4.	Specialist Consultations:	opinion or advice requested by a general dentist.

#### c. Basic Services

1.	General Anesthesia or IV Sedation:	when administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.
2.	Periodontal Cleanings:	periodontal maintenance.
3.	Palliative:	emergency treatment to relieve pain.
4.	Restorative:	amalgam and resin-based composite restorations (fillings) and prefabricated stainless steel restorations for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

#### d. Major Services

1.	Crowns and Inlays/Onlays:	treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.
----	---------------------------	--

2.	Prosthodontics:	procedures for construction of fixed bridges, partial or complete dentures and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.
3.	Oral Surgery:	extractions and certain other surgical procedures (including pre-and post-operative care).
4.	Endodontics:	treatment of diseases and injuries of the tooth pulp.
5.	Periodontics:	treatment of gums and bones supporting teeth.
6.	Denture Repairs:	repair to partial or complete dentures, including rebase procedures and relining.
7.	Night Guards/Occlusal Guards:	intraoral removable appliances provided for treatment of harmful oral habits.

### 18.9 Limitations.

- a. Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called "Optional Services". Optional Services also include the use of specialized techniques instead of standard procedures.
- b. If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means the dental plan will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.
- c. Claims shall be processed in accordance with the dental plan's standard processing policies. The processing policies may be revised from time to time; therefore, the dental plan shall use the processing policies that are in effect at the time the claim is processed. Dentists (dental consultants) may be used to review treatment plans, diagnostic materials and/or prescribed treatments to determine generally accepted dental practices and to determine if treatment has a favorable prognosis.
- d. If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the dental Benefit payable. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.
- e. Exam and cleaning limitations
  - i. The dental plan will pay for oral examinations (except after hours exams and exams for observation) and routine cleanings no more than once every six (6) months. Periodontal maintenance in the presence of inflamed gums are limited to four (4) times in a 12-month period. Up to four (4) periodontal maintenance procedures and up to two (2) routine cleanings not to exceed four (4) procedures or any combination thereof in a 12-month period.
  - ii. A full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided.
  - iii. Note that periodontal cleanings and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.
  - iv. Caries risk assessments are allowed once in 36 months for Enrollees age three (3) to 19.
- f. X-ray limitations:
  - i. The dental plan will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series.
  - ii. When a panoramic film is submitted with supplemental films, the dental plan will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series.

- iii. If a panoramic film is taken in conjunction with an intraoral complete series, the dental plan considers the panoramic film to be included in the complete series.
- iv. A complete intraoral series and panoramic film are each limited to once every 60 months.
- v. Bitewing x-rays are limited to once every six (6) months. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.
- g. The fee for pulp vitality tests are included in the fee for any definitive treatment performed on the same date.
- h. Topical application of fluoride solutions is limited to twice within a 12-month period.
- i. The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.
- j. Sealants are limited as follows:
  - i. to permanent molars if they are without caries (decay) or restorations on the occlusal surface.
  - ii. repair or replacement of a Sealant on any tooth within 36 months of its application is included in the fee for the original placement.
- k. Specialist Consultations are limited to once per lifetime per Provider and count toward the oral exam frequency.
- l. The dental plan will not cover replacement of an amalgam or resin-based composite restorations (fillings) within 24 months of treatment if the service is provided by the same Provider/Provider office. Prefabricated crowns are limited to once per Enrollee per tooth in any 60-month period. Replacement restorations within 24 months are included in the fee for the original restoration.
- m. Protective restorations (sedative fillings) are allowed when definitive treatment is not performed on the same date of service. The fee for protective restorations are included in the fee for any definitive treatment performed on the same date.
- n. Prefabricated stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16.
- o. Therapeutic pulpotomy is limited to baby (deciduous) teeth only; an allowance for an emergency palliative treatment is made when performed on permanent teeth.
- p. Pulpal therapy (resorbable filling) is limited to once in a lifetime and to primary incisor teeth for Enrollees up to age 6 and for primary molars and cuspids up to age 11. Retreatment of root canal therapy by the same Provider/Provider office within 24 months is considered part of the original procedure.
- q. Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation.
- r. Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
- s. Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.
- t. Palliative treatment is covered per visit, not per tooth, and the fee for palliative treatment provided in conjunction with any procedures other than x-rays or select Diagnostic procedures is considered included in the fee for the definitive treatment.
- u. Periodontal limitations:
  - i. Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period.
  - ii. Periodontal surgery in the same quadrant is limited to once in every 36-month period and includes any surgical re-entry or scaling and root planing.
  - iii. Periodontal services, including graft procedures are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.

- iv. Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
- v. Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.
- v. Collection and application of autologous blood concentrate product are limited to once every 36 months.
- w. Crowns and Inlays/Onlays are covered not more often than once in any 60 month period except when the dental plan determines the existing Crown or Inlay/Onlay is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.
- x. Core buildup, including any pins, are covered not more than once in any 60 month period.
- y. Resin infiltration of incipient smooth surface lesions is covered once in any 36 month period.
- z. When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.
- aa. Prosthodontic appliances, implants and/or implant supported prosthetics (except for implant/abutment supported removable dentures) that were provided under any dental program will be replaced only after 60 months have passed, except when it is determined that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a the dental program will be made if it is determined to be unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. The dental plan's payment for implant removal is limited to one (1) for each implant within a 60-month period.
- bb. Debridement and/or osseous contouring of a peri-implant defect, or defects surrounding a single implant, and includes surface cleaning of the exposed implant surface, including flap entry and closure is allowed once every 60-month period.
- cc. An implant is a covered procedure of the plan only if determined to be a dental necessity. If an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.
- dd. When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
- ee. Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within six (6) months of the initial placement.
- ff. The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under a the dental plan.
- gg. The dental plan limits payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six (6) months after placement.
  - i. Denture rebase is limited to one (1) per arch in a 36-month period and includes any relining and adjustments for six (6) months following placement.
  - ii. Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment or reline, relining are limited to one (1) per arch in a 36-month period.

- iii. Tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture, reline or rebase service.
- hh. Occlusal guards are covered by report for Enrollees age 13 or older when the purpose of the occlusal guard is for the treatment of bruxism or diagnoses other than temporomandibular joint dysfunction (TMJD). Occlusal guards are limited to one (1) per 12 consecutive month period. The repair or replacement of any appliances for Night Guard/Occlusal Guard are not covered.
- ii. Limitations on Orthodontic Services:
  - i. Services are limited to medically necessary orthodontics when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained.
- jj. 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.
- kk. The automatic qualifying conditions are:
  - i. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
  - ii. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
  - iii. A crossbite of individual anterior teeth causing destruction of soft tissue,
  - iv. Severe traumatic deviation.
- ll. The following documentation must be submitted with the request for prior authorization of services by the Provider:
  - i. ADA 2006 or newer claim form with service codes requested;
  - ii. Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
  - iii. Cephalometric radiographic image or panoramic radiographic image;
  - iv. HLD score sheet completed and signed by the Orthodontist; and
  - v. Treatment plan.
- mm. 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.
- nn. Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.
- oo. Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for Enrollees under the age of 19 and shall be prior authorized.
- pp. 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.
- qq. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- rr. When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, the dental plan will make an allowance for the cost of a standard orthodontic treatment. The Enrollee is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.
- ss. Repair and replacement of an orthodontic appliance inserted under this dental plan that has been damaged, lost, stolen, or misplaced is not a covered service.

**18.10 Exclusions. Dental Benefits are not payable for:**

- a. services that are not Essential Health Benefits.
- b. treatment of injuries or illness covered by workers' compensation or employers' liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- c. cosmetic surgery or procedures for purely cosmetic reasons.
- d. maxillofacial prosthetics.
- e. provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
- f. services for congenital (hereditary) or developmental (following birth) malformations, including cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.
- g. treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments.
- h. any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
- i. prescribed drugs, medication, pain killers, antimicrobial agents, or experimental/investigational procedures.
- j. charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
- k. extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
- l. laboratory processed crowns for Enrollees under age 12.
- m. endodontic denosseous implants.
- n. indirectly fabricated resin-based Inlays/Onlays.
- o. charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
- p. treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
- q. charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.
- r. dental practice administrative services including preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
- s. procedures having a questionable prognosis based on a dental consultant's professional review of the submitted documentation.
- t. any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
- u. Deductibles and/or any service not covered under the dental plan.
- v. services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
- w. the initial placement of any prosthodontic appliance or implants, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Contract or was covered under any dental care plan. The extraction of a third molar (wisdom tooth) will not

qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.

- x. services for any disturbance of the temporomandibular (jaw) joints (TMJ) or associated musculature, nerves and other tissues.
- y. services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a prior authorization is obtained.
- z. missed and/or cancelled appointments.

# Amendment



## Review Procedures/How to Appeal a Claim (Benefit Denial)

As of the Contract Effective Date, the Small Group Medical and Hospital Service Contract is hereby amended, as shown below.

Part XIII. REVIEW PROCEDURES/HOW TO APPEAL A CLAIM (BENEFIT DENIAL), is revised as follows (words ~~stricken~~ are deleted; words underlined are added):

### 13.3 Claims for Benefits.

Subsection a.ii.1):

- 1) Appeal of a Pre-Service Claim. AvMed shall notify the Claimant of its determination on review not 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:

Subsection b.ii.1):

- 1) Appeal of an Urgent Care Claim. AvMed shall notify the Claimant of its determination on review as soon as possible, taking into account the medical exigencies, but not 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 Relations Department, at the address listed in Section 13.3a.ii.

Subsection d.ii.1):

- 1) Appeal of a Post-Service Claim. AvMed shall notify the Claimant of the determination on review not 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 Relations Department, at the address listed in Section 13.3a.ii.

### 13.5 Review Procedure Upon Appeal.

Subsections c. through h.:

- c. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, or any new or additional rationale for our decision is considered, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination. Notwithstanding any other requirement for the timing of our decision on appeal, Claimants will be given a reasonable amount of time to respond to any new or additional evidence or rationale prior to our rendering a final internal Adverse Benefit Determination.
- ed. The appeal shall take into account all comments, documents, records and other information the Claimant submitted relating to the Claim, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
- de. The appeal shall 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 shall not defer to the initial Adverse Benefit Determination.
- ef. 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 shall consult with a Health Professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

# Amendment



- fg. The appeal shall 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.
- gh. The appeal shall provide that the Health Professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
- hi. In the case of an Urgent Care Claim, there shall be an expedited review process 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, shall be transmitted between AvMed and the Claimant by telephone, facsimile or other available similarly expeditious methods.

All other provisions of **Part XIII. REVIEW PROCEDURES/HOW TO APPEAL A CLAIM (BENEFIT DENIAL)**, remain unchanged from the original, as described in the 2018 Small Group Medical and Hospital Service Contract.

A handwritten signature in black ink, appearing to read "James M. Repp", written in a cursive style.

James M. Repp, President & COO

## Addendum to the AvMed Group Medical and Hospital Service Contract

This addendum together with the benefits provisions of the AvMed Group Medical and Hospital Service Contract (the "Contract") and the other attached documents constitute the summary plan description for this portion of your Subscribing Group's Welfare and/or Benefit Plan (the "Plan"). To the extent there are any inconsistencies between the provisions of this Addendum and the provisions of the Contract, the terms and provisions of this Addendum will govern. The official Plan document contains the full Plan details. This document does not create a contract of employment between the Subscribing Group and any employee. The Subscribing Group reserves the right to discontinue, amend or replace this Plan at its discretion at any time for any reason. If you have further questions about the Plan or would like a complete copy of the Plan document, contact your human resources representative.

### **Statement of ERISA Rights**

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

#### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series), if any, and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5599, if any is required by ERISA to be prepared, in which case, the Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

#### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan (pension/welfare) benefit or exercising your rights under ERISA.

#### **Enforce Your Rights**

If your claim for a (pension/welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500) from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a

federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory), or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.



**Small Group Achieve LG200-SG18**

Coverage for: Individual or Individual + Family| Plan Type: HMO

**⚠ The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-376-6651 or visit [www.amed.org](http://www.amed.org). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.ccio.cms.gov](http://www.ccio.cms.gov) or call 1-800-376-6651 to request a copy.**

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,500 individual / \$3,000 family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, office visits, tests & outpatient surgery at independent facilities, certain prescription drugs, urgent and emergent care, and certain recovery services, e.g., habilitation and rehabilitation services, are covered before you meet your deductible.	This plan covers some items and services if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other deductibles for specific services?	Yes. \$65 per child for Pediatric Dental. Doesn't apply to the overall deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	\$4,200 individual / \$8,400 family Pediatric Dental is limited to \$350 per child or \$700 for 2 or more children.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, pediatric dental deductible, prescription drug brand additional charges, and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See <a href="http://www.amed.org">www.amed.org</a> or call 1-800-376-6651 for a list of network providers.	You pay the least if you use a provider at an independent facility. You pay more if you use a provider at all other facilities. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an <b>AWMed Network Provider</b> (You will pay the least)	an <b>Out of Network Provider</b> (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge for first two non-preventive visits; \$25 copay/visit thereafter	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	Specialist visit	\$50 copay/ visit	Not Covered	Additional charges may apply for non-preventive services performed in the Physician's office.
	Preventive care/screening/immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$100 copay/ visit at independent facilities; \$150 copay/ visit after deductible at all other facilities; \$25 copay/ visit for lab work at certain participating labs	Not Covered	Charges for office visits may apply if services are performed in a Physician's office. Charges for certain other labs and Specialty labs will be higher.
	Imaging (CT/PET scans, MRIs)	\$350 copay/ visit at independent facilities; \$500 copay/ visit after deductible at all other facilities	Not Covered	Charges for office visits or Physician/professional services may also apply depending where services are received.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an AvMed Network Provider (You will pay the least)	an Out of Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <b>prescription drug coverage</b> is available at <a href="http://www.avmed.org">www.avmed.org</a>	Generic drugs (Tier 1)	\$10 copay/ prescription (retail); \$25 copay/ prescription (mail order)	Not Covered	Retail charge applies per 30-day supply.
	Preferred brand drugs (Tier 2)	\$40 copay/ prescription (retail); \$100 copay/ prescription (mail order)	Not Covered	Generic & brand drugs: covers up to a 90-day supply at retail pharmacies and a 60-90 day supply via mail order.
	Non-preferred brand drugs (Tier 3)	\$80 copay/ prescription (retail); \$200 copay/ prescription (mail order)	Not Covered	Certain drugs in all tiers require prior authorization.
	Specialty drugs (Tier 4)	50% coinsurance after deductible (retail only)	Not Covered	Brand additional charges may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 copay/ visit at independent facilities; \$750 copay/ visit after deductible at all other facilities	Not Covered	Specialty drugs available in 30-day supply only; not available via mail order.
	Physician/surgeon fees	No Charge	Not Covered	Prior authorization required.
If you need immediate medical attention	Emergency room care	\$500 copay/ visit	\$500 copay/ visit	AvMed must be notified within 24-hours of inpatient admission following emergency services, or as soon as reasonably possible. Charges are waived if admitted.
	Emergency medical transportation	\$150 copay/ one way ground transport	\$150 copay/ one way ground transport	50% coinsurance after deductible for air and water transportation.
	Urgent care	\$125 copay/ visit at urgent care facilities; \$25 copay/ visit at retail clinics	\$125 copay/ visit after deductible at urgent care facilities; \$25 copay/ visit after deductible at retail clinics	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 copay/ day for the first 3 days per admission after deductible	Not Covered	Prior authorization required.
	Physician/surgeon fees	No charge after deductible	Not Covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an AvMed Network Provider (You will pay the least)	an Out of Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay/ visit	Not Covered	Prior notification required.
	Inpatient services	Hospital stay: \$750 copay/ day for the first 3 days per admission after deductible; Residential stay: \$250 copay/ day for the first 5 days per admission after deductible	Not Covered	Prior authorization required. Residential stay is limited to 60 days per calendar year.
	Office visits	Routine OB: \$25 copay/ 1st visit only; subsequent visits at no charge	Not Covered	None
If you are pregnant	Childbirth/delivery professional services	Routine OB & Midwife services: \$25 copay/ 1st visit only; subsequent visits at no charge	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery facility services	Hospital stay: \$750 copay/ day for the first 3 days per admission after deductible; Birthing center: same as routine OB	Not Covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an AvMed Network Provider (You will pay the least)	an Out of Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$50 copay/ visit after deductible	Not Covered	Limited to 20 skilled visits per calendar year. Approved treatment plan required.
	<u>Rehabilitation services</u>	\$50 copay/ visit; \$25 copay/ visit for chiropractic services	Not Covered	Limited to 35 visits per calendar year for rehabilitative outpatient PT, OT, ST, cardiac rehab, and chiropractic services combined. Cardiac rehab requires prior authorization.
	<u>Habilitation services</u>	\$50 copay/ visit	Not Covered	Limited to 35 visits per calendar year for outpatient habilitative PT, OT and ST combined.
	<u>Skilled nursing care</u>	\$250 copay/ day for the first 5 days per admission after deductible	Not Covered	Limited to 60 days post-hospitalization care per calendar year. Prior authorization required.
	<u>Durable medical equipment</u>	\$100 copay/ episode of illness	Not Covered	Excludes vehicle modifications, home modifications, exercise equipment, and bathroom equipment.
	<u>Hospice services</u>	\$250 copay/ admission after deductible	Not Covered	Physician certification required.
	<u>Children's eye exam</u>	\$35 copay/ exam	Not Covered	Limited to 1 eye exam per calendar year to determine the need for sight correction.
If your child needs dental or eye care	<u>Children's glasses</u>	\$20 copay/ pair	Not Covered	Limited to 1 pair of glasses per calendar year from a pre-selected group of frames.
	<u>Children's dental check-up</u>	No charge for preventive care at Delta Dental Network providers	Preventive care may be subject to cost sharing if billed charges exceed allowed amount.	Limited to 1 exam every 6 months. See the dental attachment to your AvMed Contract for coverage details.

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

• Acupuncture	• Hearing Aids	• Private-Duty Nursing
• Bariatric Surgery	• Infertility Treatment	• Routine Eye Care (Adult)
• Cosmetic Surgery	• Long-Term Care	• Routine Foot Care
• Dental Care (Adult)	• Non-Emergency Care When Traveling Outside the U.S.	• Weight Loss Programs

**Other Covered Services (limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic Care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Florida Office of Insurance Regulation at 1-877-693-5236 or [www.flor.com/consumers](http://www.flor.com/consumers), the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or [www.dol.gov/ebsa/contactEBSA/consumerassistance.html](http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.ccoio.cms.gov](http://www.ccoio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact AVMed's Member Engagement Center at 1-800-376-6651. For plans subject to ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the Florida Department of Financial Services, Division of Consumer Services, at 1-877-693-5236 or [www.flor.com/consumers](http://www.flor.com/consumers).

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? Yes.**

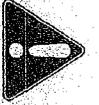
If your plan doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help pay for a plan through the **Marketplace**.

**Language Access Services:**

Para obtener asistencia en Español, llame al 1-800-376-6651.

To see examples of how this plan might cover costs for a sample medical situation, see the next section \_\_\_\_\_

**About these Coverage Examples:**



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- ☑ The plan's overall deductible **\$1,500**
- ☑ Specialist copayment **\$50**
- ☑ Hospital (facility) copayment **\$750**
- ☑ Other coinsurance **N/A**

This EXAMPLE event includes services like:  
Specialist office visits (*prenatal care*)  
Childbirth/delivery professional services  
Childbirth/delivery facility services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

**Total Example Cost** **\$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$1,790
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,290</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- ☑ The plan's overall deductible **\$1,500**
- ☑ Specialist copayment **\$50**
- ☑ Hospital (facility) copayment **\$750**
- ☑ Other coinsurance **N/A**

This EXAMPLE event includes services like:  
Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

**Total Example Cost** **\$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$4,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$4,255</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- ☑ The plan's overall deductible **\$1,500**
- ☑ Specialist copayment **\$50**
- ☑ Hospital (facility) copayment **\$750**
- ☑ Other coinsurance **N/A**

This EXAMPLE event includes services like:  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

**Total Example Cost** **\$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.



# Schedule of Benefits

**SMALL GROUP**  
ACHIEVE LG200-SG18  
SG-1087

## SCHEDULE OF BENEFITS

In-Network

Out-of-Network

DEDUCTIBLE PER CALENDAR YEAR	INDIVIDUAL / FAMILY		
		\$1,500 / \$3,000	Not Applicable
<b>OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR</b>	<b>INDIVIDUAL / FAMILY</b>		
	<i>Includes deductible, copayments and coinsurance for all covered benefits</i>	\$4,200 / \$8,400	Not Applicable

### PHYSICIAN OFFICE VISITS

Primary Care Physician Services	• Office visits (including consultations)	No charge for the first two non-preventive visits; \$25 copay per visit thereafter	Not Covered
	• Services in Physicians' offices include: <ul style="list-style-type: none"> <li>○ Minor surgical procedures</li> <li>○ Diagnostic imaging, radiology and laboratory services</li> </ul>	No additional charge	Not Covered
	• Office visits (including consultations)	\$50 copay per visit	Not Covered
	• Minor surgical procedures	\$50 copay per visit	Not Covered
Specialty Physician Services	• Diagnostic laboratory services	No Charge	Not Covered
	• Diagnostic imaging (including x-ray)	\$50 copay per visit	Not Covered
	• Advanced imaging (including MRI)	\$50 copay per visit	Not Covered
	<i>Additional charges may apply for other non-preventive services performed in the Physician's office. Office visit charges also apply.</i>		

Other Physician Services	• Allergy injections and allergy skin testing. Office visit cost sharing may also apply.	\$50 copay per visit	Not Covered
	• Podiatry services <ul style="list-style-type: none"> <li>○ Coverage includes services associated with foot care for diabetics and any other medically necessary care.</li> </ul>	\$25 copay per visit	Not Covered
	• Diabetes care management <ul style="list-style-type: none"> <li>○ Includes care, education, and nutritional counseling. <i>Nutritional counseling limited to three visits per calendar year.</i></li> </ul>	\$50 copay per visit	Not Covered



# Schedule of Benefits

**SMALL GROUP**  
**ACHIEVE LG200-SG18**  
**SG-1087**

## SCHEDULE OF BENEFITS

**In-Network**

**Out-of-Network**

Preventive Care and Services

- Preventive care services provided by a Participating Provider include:
  - Annual physical examinations and immunizations
  - Breastfeeding support and supplies
  - Colorectal cancer screening, including colonoscopies
  - HIV screening
  - Preventive radiology and laboratory services
  - Prostate specific antigen (PSA) testing
  - Routine screening mammograms
  - Voluntary family planning services
  - Well-child care and immunizations, including routine vision and hearing screenings by a pediatrician
  - Well-woman examinations, including Pap smears

*For a comprehensive list of covered preventive services, see <https://www.healthcare.gov/coverage/preventive-care-benefits/>*

**OUTPATIENT DIAGNOSTIC TESTS - Cost-sharing for diagnostic services performed in a Physician's office is shown on page 1.**

- Routine outpatient laboratory tests and blood work
  - Certain participating labs
  - Other labs
  - Specialty labs
- Imaging and non-imaging tests (including x-ray)
  - \$25 copay per visit
  - \$500 copay per visit
  - \$500 copay per visit
  - \$100 copay per visit at independent facilities;
  - \$150 copay per visit after deductible at all other facilities
  - \$350 copay per visit at independent facilities;
  - \$500 copay per visit after deductible at all other facilities
- Advanced imaging services (MRI, MRA, PET, CT, Nuclear Medicine)
  - Not Covered
  - Not Covered

*Certain services require prior authorization.*



# Schedule of Benefits

**SMALL GROUP**  
ACHIEVE 10200-SG18  
SG-1087

## SCHEDULE OF BENEFITS

In-Network

Out-of-Network

### PRESCRIPTION DRUGS

	In-Network	Out-of-Network
Generic Drugs	30 or 90 day supply available at participating retail pharmacies; 60-90 day supply via mail order \$10 copay per prescription (retail); \$25 copay per prescription (mail order)	Not Covered
Preferred Brand Drugs	30 or 90 day supply available at participating retail pharmacies; 60-90 day supply via mail order \$40 copay per prescription (retail); \$100 copay per prescription (mail order)	Not Covered
Non-Preferred Brand Drugs	30 or 90 day supply available at participating retail pharmacies; 60-90 day supply via mail order \$80 copay per prescription (retail); \$200 copay per prescription (mail order)	Not Covered
Specialty Drugs	Available in 30 day supply only; not available via mail order 50% coinsurance after deductible (retail only)	Not Covered

*Brand additional charge may apply if a Brand is selected when a Generic is available. Certain drugs require prior authorization. Retail charge applies per 30-day supply.*

### INFUSION AND OTHER DRUG THERAPY

Drug Therapy	<ul style="list-style-type: none"> <li>Drug therapy administered by a medical professional               <ul style="list-style-type: none"> <li>In a Physician's office</li> <li>In the home</li> <li>In an outpatient facility</li> </ul> </li> </ul> <i>Requires prior authorization.</i>	No charge after deductible	Not Covered
Chemotherapy	<ul style="list-style-type: none"> <li>Chemotherapy (covers administration and facility charges)</li> </ul>	No charge after deductible	Not Covered

### OUTPATIENT FACILITY SERVICES

<ul style="list-style-type: none"> <li>Outpatient surgeries (including cardiac catheterizations and angioplasty)</li> </ul>	\$500 copay per visit at independent facilities; \$750 copay per visit after deductible at all other facilities	Not Covered
<ul style="list-style-type: none"> <li>Physician and surgeon services</li> <li>Dialysis services (available from In-Network facilities and Physicians designated by AveMed as an approved dialysis provider)</li> <li>Radiation therapy</li> </ul> <i>Outpatient facility services require prior authorization.</i>	No Charge \$500 copay per visit \$500 copay per course of treatment	Not Covered Not Covered Not Covered



# Schedule of Benefits

**SMALL GROUP**  
ACHIEVE LG200-SG18  
SG-1087

## SCHEDULE OF BENEFITS

In-Network

Out-of-Network

### IMMEDIATE CARE

Emergency Services	<ul style="list-style-type: none"> <li>Emergency room services. Copay waived if admitted as an inpatient.</li> </ul> <p><i>AveMed must be notified within 24 hours of inpatient admission following emergency services or as soon as reasonably possible.</i></p>	\$500 copay per visit	\$500 copay per visit
--------------------	---	-----------------------	-----------------------

### Ambulance

<ul style="list-style-type: none"> <li>Ambulance transport for emergency services           <ul style="list-style-type: none"> <li>Ground transport</li> <li>Air and water transport</li> </ul> </li> <li>Non-emergent ambulance services are covered when the skill of medically trained personnel is required and the Member cannot be safely transported by other means. Non-emergent ambulance services require prior authorization.</li> </ul>	<p>\$150 copay per one way transport</p> <p>50% coinsurance after deductible</p> <p>\$150 copay per one way transport</p>	<p>\$150 copay per one way transport</p> <p>50% coinsurance after deductible</p> <p>\$150 copay per one way transport</p>
---	---	---

### Urgent/Immediate Care

<ul style="list-style-type: none"> <li>Medical Services at urgent/immediate care facilities</li> <li>Medical Services at a retail clinic</li> </ul>	<p>\$125 copay per visit</p> <p>\$25 copay per visit</p>	<p>\$125 copay per visit after deductible</p> <p>\$25 copay per visit after deductible</p>
---	--	--

### INPATIENT HOSPITAL

<ul style="list-style-type: none"> <li>Inpatient care at Hospitals includes:           <ul style="list-style-type: none"> <li>Room and board - unlimited days (semi-private)</li> <li>Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication</li> <li>Intensive care unit and other special units, general and special duty nursing</li> <li>Laboratory and diagnostic imaging</li> <li>Required special diets</li> <li>Radiation and inhalation therapies</li> <li>Maternity services</li> <li>Physician and surgeon services</li> </ul> </li> </ul> <p><i>Inpatient services require prior authorization.</i></p>	<p>\$750 copay per day for the first three days per admission after deductible</p> <p>No charge after deductible</p>	<p>Not Covered</p> <p>Not Covered</p>
--	--	---------------------------------------

### MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

<ul style="list-style-type: none"> <li>Office visits</li> <li>Inpatient care for acute mental health and substance use disorders, and partial hospitalization</li> <li>Inpatient intermediate residential care. <i>Limited to 60 days per calendar year.</i></li> </ul> <p><i>Inpatient services require prior authorization.</i></p>	<p>\$25 copay per visit</p> <p>\$750 copay per day for the first three days per admission after deductible</p> <p>\$250 copay per day for the first five days per admission after deductible</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>
---	--	--



# Schedule of Benefits

**SMALL GROUP**  
ACHIEVE LG200-SG18  
SG-1087

## SCHEDULE OF BENEFITS

In-Network

Out-of-Network

### MATERNITY

- Pre- and post-natal care:
    - Routine office visits \$25 copay for the first visit; subsequent visits at no charge Not Covered
    - Specialist office visits \$50 copay per visit Not Covered
    - Childbirth/delivery professional services
      - Routine OB \$25 copay for the first visit; subsequent visits at no charge Not Covered
      - Midwife services \$25 copay for the first visit; subsequent visits at no charge Not Covered
      - Childbirth/delivery facility services
        - Hospital \$750 copay per day for the first three days per admission after deductible Not Covered
        - Birthing center \$25 copay per visit Not Covered
- Inpatient services require prior authorization. Maternity care may include tests and services described elsewhere in this document (e.g. ultrasound).*

### RECOVERY

Home Health Care			
• Home health care visits	\$50 copay per visit after deductible	Not Covered	
<i>Coverage is limited to 20 skilled visits per calendar year. Approved treatment plan and prior authorization required.</i>			
Rehabilitation Services			
• Short-term physical, occupational and speech therapies for acute conditions	\$50 copay per visit	Not Covered	
• Cardiac rehabilitation for the following conditions: <ul style="list-style-type: none"> <li>○ Acute myocardial infarction</li> <li>○ Percutaneous transluminal coronary angioplasty (PTCA)</li> <li>○ Repair or replacement of heart valves</li> <li>○ Coronary artery bypass graft (CABG)</li> <li>○ Heart transplant</li> </ul>	\$50 copay per visit	Not Covered	
• Chiropractic services	\$25 copay per visit	Not Covered	
<i>Coverage is limited to 35 visits per calendar year for rehabilitative outpatient PT, OT, ST, cardiac rehabilitation, and chiropractic services combined. Cardiac rehabilitation requires prior authorization.</i>			



# Schedule of Benefits

**SMALL GROUP**  
**ACHIEVE LG200-SG18**  
**SG-1087**

## SCHEDULE OF BENEFITS

**In-Network**

**Out-of-Network**

### Habilitation Services

\$50 copay per visit

Not Covered

- Habilitative physical, occupational and speech therapies  
*Coverage is limited to a combined maximum of 35 visits per calendar year for outpatient habilitative physical, occupational and speech therapies.*

### Skilled Nursing Facilities

\$250 copay per day for the first five days per admission after deductible

Not Covered

- Skilled nursing care  
*Coverage is limited to 60 days post-hospitalization care per calendar year. Requires prior authorization.*

### Durable Medical Equipment and Orthotic Appliances

\$100 copay per episode of illness

Not Covered

- Equipment includes:
  - Standard Hospital beds
  - Walkers
  - Crutches
  - Wheelchairs
- Enteral and parenteral nutrition. *Authorization required for benefits usage in excess of \$2,500 per calendar year.*
- Orthotic appliances are limited to:
  - Leg, arm, back, and neck custom-made braces
- Prosthetic devices are limited to:
  - Artificial limbs
  - Artificial joints
  - Ocular prostheses

### Hospice

\$250 copay per admission after deductible

Not Covered

- Physician certification required

## PEDIATRIC VISION AND DENTAL SERVICES

### Pediatric Vision

\$35 copay per allowed exam

Not Covered

- One exam per calendar year to determine the need for sight correction
- One pair of eye glasses per calendar year (includes standard lenses and frames. Members may choose from a pre-selected group of frames.)

### Pediatric Dental

No charge for preventive care from Delta Dental Network providers

Preventive care may be subject to cost-sharing if billed charges exceed allowed amount.

- Dental services are subject to a separate calendar year deductible of \$65 per child.
- Cost-sharing for dental services from Delta Dental Network providers is limited to a separate out-of-pocket maximum of \$350 per child, or \$700 for two or more children. The out-of-pocket maximum does not apply to Out-of-Network benefits.
- Exams are limited to one every six months. Please see your Contract for details regarding benefits and cost-sharing.



# Schedule of Benefits

**SMALL GROUP**  
ACHIEVE LG200-SG18  
SG-1087

## SCHEDULE OF BENEFITS

In-Network

Out-of-Network

### TEMPOROMANDIBULAR JOINT DISORDER (TMJ)

- Treatment for TMJ

Same as any other illness based on type of provider and service location

Not Covered

### TRANSPLANT SERVICES

- AvMed In-Network Center of Excellence Facilities

Same as any other illness based on type of provider and service location

Not Covered

*Limitations apply. Please see your Contract for details.*

### ALL OTHER COVERED SERVICES

For cost-sharing information about items or services not listed in this document, please see your Contract, or call AvMed's Member Engagement Center at 1-800-376-6651.

**FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-376-6651.**

This Schedule of Benefits is not a contract. Please see your AvMed Small Group Plan Medical and Hospital Service Contract for specific information on benefits, exclusions and limitations.

Disclaimer: This benefit plan will be administered in accordance with the requirements of state and federal law, including the Patient Protection and Affordable Care Act.

## Key Benefits for your Plan: Achieve LG200-SG18

Benefit	Your cost if you use an	
	AyMed Network Provider	Out-of-network Provider
Coinsurance	0%	Not Covered
Deductible	\$1,500 individual / \$3,000 family	Not Covered
Other Deductible	Yes. \$65 per child for Pediatric Dental. Doesn't apply to overall deductible. There are no other specific deductibles.	Not Applicable
Out of Pocket Max (Includes Deductible)	\$4,200 individual / \$8,400 family Pediatric Dental is limited to \$350 per child or \$700 for 2 or more children.	Not Covered
PCP Cost Share	No charge for first two non-preventive visits; \$25 copay/ visit thereafter	Not Covered
Specialist Cost Share (No Referral Needed)	\$50 copay/ visit	Not Covered
Inpatient Hospital Cost Share	\$750 copay/day for the first 3 days per admission, after deductible	Not Covered
E.R. Cost Share	\$500 copay/ visit	\$500 copay/ visit
Urgent Care Cost Share	\$125 copay/ visit at urgent care facilities; \$25 copay/ visit at retail clinics	\$125 copay/ visit after deductible at urgent care facilities; \$25 copay/ visit after deductible at retail clinics
Outpatient Surgery Cost Share	\$500 copay/ visit at independent facilities; \$750 copay/ visit after deductible at all other facilities	Not Covered
Imaging Tests (CT / PET scans / MRI's) Cost Share	\$350 copay/ visit at independent facilities; \$500 copay/ visit after deductible at all other facilities	Not Covered
Drug Cost Share	Generic - \$10 copay (retail)/ \$25 copay (mail order) Preferred Brand - \$40 copay (retail)/ \$100 copay (mail order) Non-Preferred Brand - \$80 copay (retail)/ \$200 copay (mail order) Specialty - 50% coinsurance after deductible (retail only)	Not Covered