Florida Health Care Plans®

An Independent Licensee of the Blue Cross and Blue Shield Association

LARGE GROUP CERTIFICATE OF COVERAGE

2024

Florida Health Care Plans

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Referenced Documents: "*Summary of Benefits and Coverage;" "Schedule of Benefits;" "Prescription Drug Formulary;" "Medical Pharmacy Formulary;" "Provider Directory";* Endorsements, and/or Riders *(if applicable).*

Florida Health Care Plans®

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Thank you for choosing Florida Health Care Plans.

Florida Health Care Plans (FHCP), is a state certified, federally qualified, Health Maintenance Organization (HMO) accredited by the National Committee for Quality Assurance (NCQA). Since 1974, Florida Health Care Plans has been proud to have serviced the health care needs of local employer groups, individuals, and Medicare recipients in the counties of Brevard, Flagler, Seminole, St. Johns, and Volusia.

FHCP is an affiliate of Florida Blue, otherwise known as Blue Cross and Blue Shield of Florida, and an independent Licensee of the Blue Cross and Blue Shield Association.

Our mission is to provide our Members with health care and related services through dedicated employees and service partners who manage both the quality and cost of health care.

Our vision is to set the standard for managed health care in our community. We intend to be acknowledged as the leader by our Members, employees, service partners and governing body.

FHCP is a community model health plan that coordinates and integrates care across the health care system. We are wellness and prevention oriented to help you live a healthy life. We are committed to understanding the health care needs, meeting the requirements of our Members, fellow employees and service partners and exceeding expectations. We strive to do our jobs right the first time, every time.

As a Member of FHCP you have certain rights and responsibilities, and you must take an active role in the management of your health care. When you become enrolled in our plan, FHCP assumes the financial responsibility for medical services described in the handbook. Unlike most insurance programs that simply pay your medical bills, FHCP views your health care as a partnership between FHCP and you by providing preventive health care. In this way, together we can help prevent minor medical concerns from becoming major medical concerns.

This Certificate of Coverage will evidence the existence of the Group Plan and describe the rights and obligations which the Member and FHCP have with respect to the coverage and/or benefits to be provided.

I approve of this form.

David C. Schandel, Chief Executive Officer

Section 1: Glossary

The following definitions are used in this Certificate of Coverage. Other definitions may be found in the specific Section or Sub-section, Attachments, Amendments, Endorsements, and Riders where they are used.

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 natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

Activities of Daily Living (ADLs) means activities such as bathing, getting dressed, using the toilet facility, eating, and moving place to place. Health professionals may gauge the functional status of an individual by their ability to perform ADLs.

Adoption or Adopt(ed) means the process and act of creating a legal parent/child relationship declaring that the child is legally the child of the adoptive parents and their heir-at-law and entitled to all the rights and privileges and subject to all the obligations of a child born to such adoptive parents, or as otherwise defined by Florida law.

Adverse Benefit Determination means any denial, reduction, or termination of coverage, benefits, or payment *(in whole or in part)* under this Certificate of Coverage with respect to a Pre-Service Claim *(*i.e., *Prior authorization / Referral)* or a Post-Service Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision, as described in the "*Claims Review"* Section, shall also constitute an Adverse Benefit Determination.

Allowance or Allowable means the maximum amount FHCP will pay to Non-Contracted Providers for Covered Services. This amount is determined solely by FHCP and is based upon many factors, including but not limited to: (1) payment for such Covered Services under the Medicare and/or Medicaid programs; (2) payment often accepted for such Covered Services by that provider and/or by other providers, either in Brevard, Flagler, Seminole, St. Johns, or Volusia Counties or in other comparable market(s), that FHCP determines are comparable to the provider that rendered the specific Covered Service(s).

Ambulance means a ground or water vehicle, airplane, or helicopter properly licensed pursuant to the *Florida Statutes*, or a similar applicable law in another state.

Ambulatory Surgical Center means a facility properly licensed pursuant *Florida Statutes*, or similar applicable laws of another state the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day. As used herein an Ambulatory Surgical Center cannot be a part of a Hospital.

Anniversary Date means the date one year after the Effective Date stated on the Group Application, and subsequent annual anniversaries.

Appeal means a request filed by a Member, Member's authorized representative, or Physician acting on a Member's behalf, requesting review of a denied pre-service claim or post-service claim. (See the "*Complaint, Grievance, and Appeal Processes"* Section.)

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

Artificial Insemination (AI) means a medical procedure in which sperm is placed into the female reproductive tract by a qualified health care provider for the purpose of producing a pregnancy. **This procedure is excluded**. (See "*Exclusions and Limitations"* Section.)

Authorized Representative of a Member means a person a Member has designated **both** verbally and in writing to represent him/her in the filing of a complaint, grievance, or an appeal. In the event the Member is a minor dependent child the authorized representative is automatically the parent or legal guardian.

Autism Spectrum Disorders; Pervasive Developmental Disorder *(not otherwise specified*); Childhood Disintegrative Disorder; and Down's Syndrome means any of the following disorders as defined in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-10 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorder:

1. Autistic disorder;
2. Asperger's syndrome;
3. Pervasive developmental disorder not otherwise specified;
4. Childhood Disintegrative Disorder; and

5. Down’s syndrome.

Bariatric Surgery means procedures such as gastric by-pass, gastric balloons, jaw wiring, jejunal by-pass, gastric banding / lap-band, gastric shunts, or others that are performed specifically for the purpose of restricting the Member’s ability to assimilate food. (See the “Exclusions and Limitations” Section.)

Birthing Center means a facility or institution, other than a Hospital or Ambulatory Surgical Center, which is properly licensed pursuant to the *Florida Statutes*, or a similar applicable law of another state, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or non-ablative therapy with curative or life-prolonging intent. 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 drugs. 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 or supplies 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).

Breast Reconstructive Surgery means surgery to re-establish symmetry between the two breasts.

Calendar Year begins January 1st and ends December 31st.

Cardiac Rehabilitation means Health Care Services provided under the supervision of a Physician, or an appropriate 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.

Certified Nurse Midwife means a person who is licensed pursuant to *Florida Statutes,* or similar applicable laws of another state, as an advanced nurse practitioner and is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a person who is a properly licensed nurse and is a certified advanced registered nurse practitioner within the nurse anesthetist category pursuant to *Florida Statutes*, or similar applicable laws of another State.

Claim Involving Urgent Care means any request or application for coverage or benefits for medical care or treatment that has been provided to the Member with respect to a situation that: (1) could seriously jeopardize the Member's life or health or his or her ability to regain maximum function; or (2) 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 proposed services being rendered.

Clinical Laboratory See *"Independent Clinical Laboratory."*

Clinical Review / Benefit Review Panel is a group of professionals designated by FHCP that will review Member appeals. The Panel consists of licensed professionals including Physicians, licensed in accordance with the *Florida Statutes*. The Physician reviewer(s) will be of the same or like specialty of the services being appealed and will not have been involved in making the initial adverse determination (Denial). (See the "*Complaint, Grievance, and Appeal Processes*" Section.)

Coinsurance, when applicable to your plan (See your "Summary of Benefits and Coverage" and your "Schedule of Benefits"), means the sharing of health care expenses for Covered Services between FHCP and the Member. After any applicable Deductible requirement is met, FHCP will pay a percentage of the Allowance for Covered Services, as set forth in the "Summary of Benefits and Coverage" and the "Schedule of Benefits." The percentage the Member is responsible for is the Member's Coinsurance.

Complaint means an oral *(non-written)* expression of dissatisfaction, whether or not such dissatisfaction was made in person, by telephone, or on the Member's behalf. (See the *"Complaint, Grievance, and Appeal Processes"* Section.)

Concurrent Care Decision means a review and decision by FHCP to deny, reduce, or terminate coverage, benefits, or payment *(in whole or in part)* with respect to a course of treatment to be provided over a period of time or for a specific number of treatments. As defined herein, a Concurrent Care Claim Review & Decision shall not include any requests by a Provider or Member for extension of services the Member has already received. Please see the "*Case Management*" sub-section in the "*Coverage Access Rules"* Section of this Certificate of Coverage.

Condition means a disease, illness, ailment, injury, bodily malfunction, or pregnancy.

Contract Year means a one-year period following the effective date stated on the Group's application.

Contracted Provider means any health care institution, facility, pharmacy, Physician, or other health care provider who has entered into a contract with FHCP for the provision of Health Care Services.

Copayment (Copay) means the fixed dollar amount, established solely by FHCP, which must be paid to a health care provider by a Member at the time certain Covered Services are rendered by that provider. While this amount may vary depending on, among other things, the contracted status of the health care provider rendering the Service and the type of Service being rendered, in no event will such amount exceed the amount specified in the Plan "*Summary of Benefits and Coverage"* and *"Schedule of Benefits"* for the service. Except as otherwise established solely by FHCP, if more than one Covered Service is rendered by a health care provider during a single office visit, the Copayment may apply to each service rendered during that visit.

Covered Dependent means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and is enrolled and covered, under the Group Plan, other than as a Subscriber. (See the "E*ligibility Requirements for Dependent(s)*" sub-section of the "*Eligibility for Membership*" Section.)

Covered Services means those Medically Necessary Health Care Services and/or supplies described in the "*Covered Medical Services*" Section. The terms "Health Care Services" and "Supplies" include treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, and chemical compounds.

Creditable Coverage means health care coverage which is continuous to a date within 63 days of the Member's Enrollment Date. Such health care coverage may include any of the following:

1. A group health plan;
2. Individual health insurance;
3. Medicare Part A and Part B;
4. Medicaid;
5. Benefits to Members and certain former Members of the uniformed services and their dependents;

6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under chapter 89 of Title 5, United States Code;
9. A public health plan;
10. A health benefit plan of the Peace Corps;
11. Children's Health Insurance Program (CHIP); and
12. Public health plans established by the federal government.

Crisis Intervention means acute inpatient psychiatric care which is required for evaluation of an acute psychosis or crisis situation in which the patient presents as a danger to self or others. The acute or crisis situation may be an exacerbation of a history of mental illness or the sudden onset of a psychiatric disorder. The crisis or acute period normally extends 48 to 72 hours but may be of greater duration depending upon the response to therapy.

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, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered regardless of the location where such care is rendered. Custodial Care is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the level of care and medical supervision required and furnished. A determination that care received is Custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

Deductible, when applicable to your plan (See your "*Summary of Benefits and Coverage"* and your "*Schedule of Benefits"*), means the amount of charges for Covered Services which a Member must actually pay to an appropriate licensed health care provider, who is recognized for payment under this Certificate of Coverage, before FHCP's payment for Covered Services begins.

Dependent means an individual who meets and continues to meet all applicable eligibility requirements described in the "Eligibility Requirements for Dependents" sub-section of the "Eligibility for Membership" Section in this Certificate of Coverage and is eligible to enroll as a Dependent.

Detoxification means a process whereby a Member who is intoxicated, or dependent on alcohol or drugs 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 Physician, while keeping the physiological risk to the Member at a minimum.

Diabetes Care and Education Specialist means a person who is properly certified pursuant to Florida law, or similar applicable laws of another state, to supervise diabetes outpatient self-management training and educational services.

Diagnostic Testing Facility means a facility, independent of a Hospital or Physician's office, which is a fixed location, a mobile entity, or an individual non-physician practitioner where diagnostic tests are performed by a licensed Physician or by licensed and certified non-physician personnel under appropriate Physician supervision. An Independent Diagnostic Testing Facility must be appropriately registered with the Agency for Health Care Administration and must comply with all applicable *Florida Statutes* or similar applicable laws of another state in which it operates. Further, such an entity must meet FHCP's criteria for eligibility as an Independent Diagnostic Testing Facility.

Dialysis Center means an outpatient facility certified by the Centers for Medicare and Medicaid Services (CMS) and the Florida Agency for Health Care Administration (or a similar regulatory agency of another state) to provide hemodialysis and peritoneal dialysis services and support.

Dietitian means a person who is properly licensed pursuant to Florida law or similar applicable laws of another State to provide nutrition counseling for diabetes outpatient self-management services.

Domestic Partner means a person in a mutual, committed relationship with the Subscriber. Who is at least 18 years of age; is not legally married to someone else; is not related to the Subscriber by blood; is residing with the Subscriber not for the sole purpose of obtaining insurance and intends to reside with the Subscriber indefinitely; who has shared financial responsibility with the Subscriber and is mentally competent to consent to a contract. (See the "*Eligibility Requirements for Dependent(s*)" sub-section of the "*Eligibility for Membership*" Section.)

Durable Medical Equipment means equipment furnished by a supplier or a Home Health Agency that (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose; (3) is not for comfort or convenience; (4) generally, is not useful to an individual in the absence of a Condition; and (5) is appropriate for use in the home.

Durable Medical Equipment Provider means a person or entity that is properly licensed, if applicable, under Florida law *(or similar applicable laws of another State)* to provide home medical equipment, oxygen therapy services, or dialysis supplies in the patient's home under a Physician's prescription.

Effective Date means, with respect to the Group and to Members properly enrolled when coverage first becomes effective, means 12:01 a.m. on the date specified on the Group application; and with respect to Members subsequently enrolled, means 12:01 a.m. on the date on which coverage will commence as specified in the *"Enrollment and Effective Date of Coverage"* Section.

Eligible Dependent means an individual who meets and continues to meet all applicable eligibility requirements described in the "Eligibility Requirements for Dependents" sub-section of the *"Eligibility for Membership"* Section in this Certificate of Coverage and is eligible to enroll as a Dependent.

Eligible Employee means an individual who meets and continues to meet all the eligibility requirements described in the "*Eligibility Requirements for Subscribers*" sub-section of the *"Eligibility for Membership" S*ection of this Certificate of Coverage and is eligible to enroll as a Subscriber. Any individual who is an Eligible Employee is not a Subscriber until such individual has actually enrolled with, and been accepted for coverage, as a Subscriber by FHCP.

Embedded Deductible Plan means a type of plan where no individual covered under a family plan will have to pay a deductible amount higher than the individual deductible amount under that same plan.

Embedded Maximum Out-of-Pocket means a type of plan where no individual covered under a family plan can be required to pay more in annual cost-sharing than a single person covered under an individual plan even though under family coverage there is a higher overall Out-of-Pocket maximum.

Emergency Medical Condition, a medical condition brought on by acute symptoms of sufficient severity *(including severe pain)* such that a prudent layperson, with an average knowledge of health and medicine could reasonably expect that not getting immediate medical attention could result in:

1. Serious jeopardy to the health of a patient, including a pregnant woman or fetus;
2. Serious impairment of bodily functions;
3. Serious dysfunction of any bodily organ or part; or

4. With respect to a pregnant woman:
    a. That there is inadequate time to affect safe transfer to another Hospital prior to delivery;
    b. That a transfer may pose a threat to the health and safety of the patient or fetus; or
    c. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency Services and Care means Medically Necessary medical screening, examination, and evaluation, by a Physician or by other appropriate personnel under the supervision of a Physician, to the extent permitted by applicable law to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, outpatient observation, inpatient or outpatient stay, or surgery by a Physician necessary to relieve or eliminate the Emergency Medical Condition, within the service capability of a Hospital or Stand-Alone Emergency Center as defined in this Section.

Endorsement means an amendment to the Master Policy or this Certificate of Coverage issued by FHCP. Note: Endorsements are also sometimes referred to as Amendments.

Enrollment Date means the date of enrollment of the individual in this Group Plan or, if earlier, the first day of the Waiting Period of such enrollment.

Experimental or **Investigational** means 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 solely by FHCP:

1. Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration 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;
2. 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;
3. Such evaluation, treatment, therapy, or device that 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;

4. 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 dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question;
5. 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 dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question;
6. 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, using generally accepted scientific, medical, or public health methodologies or statistical practices;
7. There is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the condition in question; or
8. 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.

FDA means the United States Food and Drug Administration.

FHCP means Florida Health Care Plan, Inc., doing business as Florida Health Care Plans an Independent Licensee of the Blue Cross & Blue Shield Association and an affiliate of Blue Cross & Blue Shield of Florida operating in the Florida counties of Brevard, Flagler, Seminole, St. Johns, and Volusia, as a Health Maintenance Organization under applicable provisions of Federal and/or State law.

Formulary means a list of drugs recommended for use under a Group Plan that includes an FHCP Pharmacy Benefit ("*Prescription Drug Formulary"*), or a listing of drugs covered under the Group's Medical benefit ("*Medical Pharmacy Formulary*").

Gamete Intrafallopian Transfer (GIFT) means the direct transfer of a mixture of sperm and eggs into the fallopian tube by a qualified health care provider. Fertilization takes place inside the tube. **This procedure is excluded.** (See the *"Exclusions and Limitations"* Section.)

Gender Dysphoria means a marked incongruence (*conflict*) between an individual's experienced / expressed gender and gender assigned at birth as manifested by at least two (2) or more of the of the following:

1. A marked incongruence (conflict) between an individual's experience / gender and primary and/or secondary sex characteristics *(or in your adolescents, the anticipated secondary sex characteristic)*;
2. An individual's strong desire to be rid of their primary and/or secondary sex characteristics of the other gender;
3. An individual's strong desire for the primary and/or secondary sex characteristics of the other gender;
4. An individual's desire to be of the other gender (*or some alternative gender different from the individuals assigned gender);*
5. An individual's strong desire to be treated as the other gender (*or some alternative gender different from the individuals assigned gender)*; or
6. An individual's strong conviction that they have the typical feelings and reactions of the other gender (*or some alternative gender different from the individuals assigned gender)*.

The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. (See the *"Covered Medical Services"* and *"Exclusion and Limitations"* Sections.)

Generally Accepted Standards of Medical Practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Gestational Surrogacy Contract or Arrangement means an oral or written agreement, regardless of the state or jurisdiction where executed, between the Gestational Surrogate and the intended parent or parents. **Medical expenses incurred under this arrangement are excluded under this plan**. (See the *"Exclusions and Limitations"* Section.)

Gestational Surrogate means a woman, regardless of age, who contracts, orally or in writing, to become pregnant by means of assisted reproductive technology without the use of an egg from her body. **Medical expenses incurred by the Surrogate under this arrangement are excluded under this plan**. (See the *"Exclusions and Limitations"* Section.)

Grace Period means a period of 10 days after the due date for FHCP to receive late Premium payments. During this 10-day grace period the group's contract will remain in force.

Grandfathered Plan means any health plan in existence prior to March 23, 2010 with current Subscribers.

Grievance means a written or, in the case of a specific time sensitive issue, a verbal expression of dissatisfaction or complaint. The Member, the Member's authorized representative, a provider authorized to act on his or her behalf, or a state agency may submit a Grievance. (See the "*Complaint, Grievance, and Appeal Processes*" Section.)

Group means the employer, partnership, corporation, department or other organization or entity through which coverage and benefits are issued by FHCP, and through which Subscribers and Dependents become entitled to the Covered Services described herein.

Group Application means the forms, electronic *(where available)* or paper, acceptable to FHCP which the Group must submit to FHCP when requesting issuance of the Master Policy.

Group Health Employee Application / Change Form means the form(s) provided by or acceptable to FHCP which a Subscriber must complete and submit to FHCP when adding or deleting a Dependent.

Group Plan means the group health benefit plan established and maintained by the Group through the purchase of comprehensive health care coverage and benefits from FHCP.

Habilitation Services means services that help a person keep, learn (attain), or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at an expected age. (See *"Autism Spectrum Disorders"* in the *"Covered Medical Services"* Section and the *"Exclusions and Limitations"* Section.)

Habilitative Therapies means therapies the primary purpose of which is to keep, attain, or improve skills and function and include but are not limited to: Physical Therapy, Speech /Language Therapies, and other services in an inpatient and/or outpatient setting. (See "*Autism Spectrum Disorders*" in the *"Covered Medical Services"* and the "Exclusions and Limitations" Sections.)

Health Care Service or Services means evaluations, treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied, by or at the direction of, providers.

Home Health Agency means a properly licensed agency or organization which provides health Services in the home pursuant to the *Florida Statutes* or similar applicable laws of another state.

Home Health Care or Home Health Care Services 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 an individual's home or residence. For purposes of this definition, a Hospital, Skilled Nursing Facility, nursing home or other facility will not be considered an individual's home or residence.

Hospice means a public agency or private organization which is duly licensed by the State of Florida under applicable law, or similar applicable laws of another state, to provide Hospice Services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill persons and their families.

Hospital means a facility properly licensed pursuant to the *Florida Statutes*, or similar applicable laws of another state, 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 Surgical Center; a Skilled Nursing Facility; a stand-alone Birthing Center; a facility for diagnosis, care, and treatment of mental and nervous disorders or alcoholism and drug dependency; a convalescent, rest or nursing home; or a facility which primarily provides custodial, educational, or rehabilitative care.

Note: If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission of the Accreditation of Health Care Organizations, 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.

Independent Clinical Laboratory means a laboratory (Lab), independent of (not owned or operated by) a Hospital or Physician's office, which is in a fixed location, properly licensed pursuant to the *Florida Statutes*, or similar applicable laws of another state, where specimens may be collected and/or examinations are performed on materials or specimens taken from the human body to provide information or materials used in the diagnosis, prevention, or treatment of a condition.

Individual Application for Group Insurance / Membership means the "*Group Health Employee Application/Change form*(s)" provided by or acceptable to FHCP, which an individual must complete and submit to FHCP when applying for Membership as a Subscriber.

Intellectual Disability means a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.

Intensive Outpatient Program (IOPs) means a direct services treatment program for people with substance use disorders or other mental / behavioral health disorders who do not require medical detoxification or 24-hour supervision. IOPs are alternatives to inpatient and residential treatment. They are designed to establish psychosocial supports and facilitate relapse management and coping strategies. These services can be provided in both group and/or individual setting and are designed to establish support mechanisms, help with relapse management, and provide coping strategies. To be covered prior authorization is required. (See the *"Behavioral, Mental Health & Substance Dependency Services"* Section.)

In Vitro Fertilization (IVF) means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to the woman's uterus**. This procedure is excluded**. (See the *"Exclusions and Limitations"* Section*.)*

Large Group means an Employer Group with 51 or more employees.

Licensed Practical Nurse means a person properly licensed to practice practical nursing pursuant to the *Florida Statues*, or similar applicable laws of another state.

Litholink means a specific provider of services designed to assist in preventing recurrent kidney stone formation in patients. Litholink provides laboratory, educational, and Physician consulting services.

Massage or Massage Therapy means the manipulation of superficial tissues of the human body using the hand, foot, arm, or elbow. For purposes of this Certificate of Coverage, the term Massage or Massage Therapy does not include the application or use of the following or similar techniques or items for the purpose of aiding in the manipulation of superficial tissues: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; or contrast baths. **This procedure is excluded**. (See the "*Exclusions and Limitations"* Section.)

Massage Therapist means a person properly licensed to practice massage therapy pursuant the *Florida Statutes*, or similar applicable laws of another state. **This service is excluded.** (See the "*Exclusions and Limitations*" Section.*)*

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

Maximum Out-of-Pocket means the most you will pay during a policy or contract period *(Usually one year)* or calendar year, before the health plan (FHCP) starts to pay 100% for covered services or supplies. This maximum amount you will have to pay includes: Deductibles, Coinsurance, Copayments, and similar covered prescription drug charges. **The following costs DO NOT apply to your Maximum Out-of-Pocket expenses:**

1. Plan Premiums;
2. Balance Billing for out-of-network providers under a Point-of-Service or Triple Option plan;
3. Costs for non-covered services or supplies (See the "Exclusions & Limitations" Section);
4. *Cost for non-covered prescription drugs or supplies (See the "Prescription Drug* Coverage" Section); and
5. Drug Cost-sharing assistance through manufacturer discount plans, grants and other foundation assistance, manufacturer coupons, and/or other third-party entities.

Medical Brace Device means any rigid device needed to support a weak or deformed body part or to restrict or eliminated body movement. (See the *"Covered Medical Services"* and *"Exclusions and Limitations"* Sections).

Medical Literature means scientific studies published in a United States peer-reviewed national professional journal.

Medical Pharmacy means medications that are administered by a health care provider in an office or an outpatient setting. This includes certain chemotherapy, therapeutic injections and other medications ordered and administered by a provider. (See the "*Covered Medical Services"* Section.)

Medical Weight Control Program means a program provided by licensed health care professionals such as Physicians, ARNPs, Registered Dieticians, and/or mental health counselors. These programs typically offer such services as nutrition counseling, physical activity counseling, and behavioral counseling. To access such services requires that the Member must meet specific medical based criteria and obtain prior authorization from his/her PCP to a contracted medical weight management program. (See the "*Exclusions and Limitations*" Section.)

Note: If you have a Triple Option or Point of Service (POS) Plan Utilization of any Out-of-Network Providers for any of these services will NOT be covered under your POS or Triple Option Plan.

Medically Necessary or **Medical Necessity** means that, health care service(s), medications, or drugs provided to the Member were for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that the health care service was:

1. In accordance with Generally Accepted Standards of Medical Practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Member's illness, injury or disease; and
3. Not primarily for the Member's convenience, or that of the Member's Physician or other health care provider, and not more costly than an alternative service or sequence of service(s), medications, or drugs at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness.

Note: It is important to remember that any review of Medical Necessity by FHCP is solely for the purpose of determining coverage or benefits under the Group Plan and as describing in this Certificate of Coverage and not for the purpose of recommending or providing medical care. In this respect, FHCP may review specific medical facts or information pertaining to the Member. Any such review, however, is strictly for the purpose of determining, among other things, whether a service provided or proposed meets the definition of Medical Necessity in this Certificate of Coverage as determined by FHCP. In applying the definition of Medical Necessity in this Certificate of Coverage**,** FHCP may apply its coverage and payment guidelines then in effect. The Member is free to obtain a service even if FHCP denies coverage because the service is not Medically Necessary. However, the Member will be solely responsible for paying for the service.

Medicare means the Federal health insurance provided under Title XVIII of the Social Security Act and all amendments thereto.

Member means any Subscriber or the Subscriber's eligible Dependent(s).

Membership means having the status of being a current Member.

Membership Card means the identification card issued by FHCP to Members. The Membership Card is the property of FHCP and is not transferable to another person. Possession of such Membership Card in no way verifies that a particular individual is eligible for or covered under the Group Plan.

Mental Health Professional means a person properly licensed to treat mental health problems pursuant to the *Florida Statutes*, or similar applicable laws of another state. This professional may be a clinical social worker, mental health counselor or marriage and family therapist. A Mental Health Professional does not include members of any religious denomination or sect who provides counseling services.

Mental and Nervous Disorder means any disorder listed in the diagnostic categories of the International Classification of Disease, Ninth Edition, Clinical Modification (ICD-10 CM), or their equivalents in most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause or effect of the disorder.

Midwife means a person properly licensed to practice midwifery pursuant to the *Florida* Statutes, or similar applicable laws of another state.

Network or Provider Network means a set of doctors, hospitals, and other health care providers such as Nurse Practitioners, Therapists, and other clinicians that are a part of your FHCP Benefit Plan. Providers are part of FHCP's network because they have agreed to see, FHCP Members, have agreed to accept FHCP's contracted rate for payment of their services, and have been selected based on FHCP's requirements to ensure that Members have accessible, quality, and safe care.

Non-Contracted Provider means any health care institution, facility, pharmacy, Physician, or other health care provider with whom FHCP does not have a direct contract in effect at the time the health care services are provided.

Non-Embedded Deductible Plan means a type of plan where the total family deductible must be paid before the FHCP begins to pay for covered benefits for any one individual covered under the plan.

Non-Embedded Maximum Out-of-Pocket means a type of plan where the individual maximum Out-of-Pocket only applies to those Members with single coverage. Those Members with family coverage must satisfy the family maximum Out-of-Pocket limit before FHCP will pay for all covered benefits at 100%.

Non-Grandfathered Plan means any health plan available to Subscribers created by FHCP on or after March 23, 2010, sometimes referred to as an ACA Plan, meaning a Plan subject to provisions of the Federal Affordable Care Act (ACA).

No Show Charge means a charge an FHCP Member can incur as the result of the Member's failure to notify a Provider's office that he/she is cancelling a scheduled appointment. Notification by the Member of a cancellation must be received by the Provider's office no later than 24 hours prior to the time of the scheduled appointment for the Member to avoid a no-show charge. *(*See *"Costs"* in the *"Exclusions & Limitations"* Section.)

Occupational Therapy means a treatment that follows an illness or injury and is designed to help a patient learn to use a newly restored or previously impaired function.

Occupational Therapist means a person properly licensed to practice occupational therapy pursuant to the *Florida Statutes*, or similar applicable laws of another state.

Orthotic Device See "*Medical Brace Device"* in this Section, the *"Covered Medical Services"* Section and "*Arch Supports"* in the *"Exclusions and Limitations"* Section.

Pain Management includes, but is not limited to, services for pain assessment, medication, Physical Therapy, biofeedback, and/or counseling. Pain rehabilitation programs are programs featuring multidisciplinary services directed toward helping those with chronic pain to reduce or limit their pain.

Partial Hospitalization means a structured, short term treatment program that offers nursing care and active participation in a treatment program that is operable a minimum of 6 hours per day, 5 days per week. A Hospital shall not be considered a "home" for purposes of this definition.

Physical Therapist means a person properly licensed to practice physical therapy pursuant to the *Florida Statutes*, or similar applicable laws of another state.

Physical Therapy means the treatment, prescribed by a Physician, of disease or injury by physical or mechanical means as defined the *Florida Statutes* or similar applicable laws of another state. Such therapy may include traction, active or passive exercises, or heat therapy.

Physician means any individual who is properly licensed by the State of Florida, or similar applicable laws of another state, as a Doctor of Medicine (*M.D*.), Doctor of Osteopathy (*D.O*.), Doctor of Podiatry (*D.P.M.*), Doctor of Chiropractic (*D.C*), Doctor of Dental Surgery or Dental Medicine (*D.D.S.* or *D.M.D*), or Doctor of Optometry (*O.D*.).

Physician Assistant means a person properly licensed to perform surgical first assisting services pursuant to the *Florida Statutes*, or similar applicable laws of another state.

Physician Specialty Society means a United States medical specialty society that represents diplomats certified by a board recognized by the American Board of Medical Specialties.

Point-of-Service (POS) Plan means a type of Group HMO Plan that allows Plan Members to have benefits for, and access to, both contracted and non-contracted appropriately licensed health care providers, who are recognized for payment under this Certificate of Coverage. This type of Plan also allows Members to access any contracted and non-contracted specialist(s) without the need of a Prior Authorization by a Primary Care Physician and/or FHCP. The financial responsibility of the Member will depend upon the contracted or non-contracted status of the health care provider who rendered the service(s). See your Point-of-Service (POS) Plan "*Summary of Benefits and Coverage"* and *"Schedule of Benefits"* for additional information regarding benefits including applicable copayments, coinsurance, deductibles, and/or balance billings. Additional special access and/or limitation rules may apply.

Note: All of the provisions of this Certificate of Coverage still apply to Member's with a Point-of-Service Plan.

Post-Service Claim means any paper or electronic request or application for coverage, benefits, or payment for a Service actually provided to the Member *(not just proposed or recommended)* that is received by FHCP in a format acceptable to FHCP in accordance with the provisions of the "*Claims Review*" Section.

Pre-Certification means the process of contacting FHCP for the purpose of recording a coverage request for certain services prior to the services being rendered. This applies when a Member is admitted to a hospital and/or has specific type of Plan *(POS or Triple Option Plan Members* see your Plan *"Summary of Benefits and Coverage"* and *"Schedule of Benefits"*). This is a data entry process and does not require judgment, medical review, or interpretation for benefit coverage.

Premium means the amount required to be paid periodically by the Group on behalf of Members enrolled hereunder.

Prescription Drug means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound which can only be dispensed with a prescription and/or which is required by state law to bear the following statement or similar statement on the label: "*Caution: Federal law prohibits dispensing without a prescription".*

Pre-Service Claim also known as Prior authorization or Referral means any request or application for coverage or benefits for a service that has not yet been provided to the Member. A Pre-Service Claim may be a Claim involving Urgent Care.

Primary Care Physician (PCP) means the Physician who provides primary care medical Services to Members under a Primary Care Physician provider contract with FHCP. A Primary Care Physician may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/ gynecologist may elect to contract with FHCP as a Primary Care Physician. Refer to the Primary Care Physicians Section(s) of the Provider Directory for Physicians who are Primary Care Physicians.

Prior Authorization also known as a Pre-Service Claim or Referral means the process of making a coverage determination which may require the review of FHCP documents and clinical information regarding the service or supply to determine whether clinical guidelines/criteria for coverage are met. Coverage decisions may be based on plan benefits and/or medical necessity based on nationally recognized guidelines and criteria.

Prior / Concurrent Coverage Affidavit means the form that an Eligible Employee can submit to FHCP as proof of the amount of time the Eligible Employee was covered under Creditable Coverage. This is optional information and is not a requirement of the enrollment process.

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.

Prosthetist/Orthotist means a person or entity that is properly licensed, if applicable, under Florida law, or similar applicable laws of another State, to provide services consisting of the design and fabrication of medical devices such as braces, splints, and artificial limbs prescribed by a Physician.

Psychiatric Facility means a facility properly licensed under Florida law, or similar applicable laws of another state, to provide for the care and treatment of Mental and Nervous Disorders. For coverage purposes, a Psychiatric Facility is not a Hospital, as defined herein.

Psychologist means a person properly licensed to practice psychology pursuant to the *Florida Statutes*, or similar applicable laws of another state.

Pulmonary Rehabilitation means services provided for the purpose of aiding in the restoration of lung function lost due to acute exacerbation of Chronic Obstructive Pulmonary Disease, post Lung resection, or transplant surgery.

Qualified Health Plan means a Plan submitted to the Federal and/or applicable State agencies by an Insurer that has been approved for inclusion in the Federal and/or State Insurance Exchange Marketplace(s). FHCP offers Qualified Health Plans (*QHPs*).

Rescission of Eligibility means a cancellation or discontinuance of coverage that has a retro-active effect, except when the recession is due to a failure to timely pay required premiums or contributions toward the cost of coverage or fraud.

Referrals see "*Prior Authorization"* and *"Pre-Service Claim"* in this Section.

Registered Nurse means a person properly licensed to practice professional nursing pursuant to the *Florida Statutes* or similar applicable laws of another state.

Registered Nurse First Assistant (RNFA) means a person properly licensed to perform surgical first assisting services pursuant to the *Florida Statutes* or similar applicable laws of another state.

Rehabilitation Services means services for the purpose of restoring function lost due to illness, injury, or surgical procedures including but not limited to Cardiac Rehabilitation, Pulmonary Rehabilitation, Occupational Therapy, Speech Therapy, and Physical Therapy.

Rehabilitative Therapies means therapies the primary purpose of which is to restore or improve bodily or mental function impaired or eliminated by a condition. This includes, but is not limited to, Physical Therapy, Speech Therapy, Pain Management, Pulmonary Therapy, or Cardiac Therapy.

Rehabilitation Treatment Center is a center that is properly licensed as a sub-acute or intermediate care facility pursuant to the *Florida Statutes*. Care and treatment are available 24 hours per day, 7 days per week and requires a skilled level of care by licensed Physicians, nurses, and mental health professionals.

Residential Treatment Center is a center properly licensed to operate as a sub-acute or intermediate care facility pursuant to the *Florida Statutes*. Such facilities must provide treatment services 24 hours per day. A minimum of one Physician visit per week in the facility setting is required to manage and update the plan of care.

Service Area means the geographic areas of Brevard, Flagler, Seminole, St. Johns, and Volusia counties in the State of Florida.

Skilled Nursing Facility means an institution or part thereof which:

1. Is licensed as a Skilled Nursing Facility by the State of Florida or similar applicable laws of another state;
2. Is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by FHCP; and
3. Provides Covered Services that are Skilled Medical Services, as determined by FHCP, to Members under a contract then in effect.

Sound Natural Teeth 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. Teeth previously restored with a crown, in-lay, on-lay, or porcelain restoration, or treated with endodontics, are not Sound Natural Teeth.

Specialist means a Physician who limits practice to specific services or procedures (e.g., surgery, radiology, pathology), certain age categories of patients (e.g., pediatrics, geriatrics), certain body systems (e.g., dermatology, orthopedics, cardiology, internal medicine) or types of diseases (e.g., allergy, psychiatry, infectious diseases, oncology). Specialists may have special education and training related to their respective practice and may or may not be certified by a related specialty board. (*Refer to the Physicians who are listed under Specialty Physicians in the FHCP Provider Directory.*)

Speech Therapist means a person properly licensed to practice speech therapy pursuant to the *Florida Statutes* or similar applicable laws of another state.

Speech Therapy means the treatment of speech and language disorders by a Speech Therapist including language assessment and language restorative therapy Services.

Stand-Alone Emergency Center sometimes referred to as a Freestanding Emergency Department (*FSED*) means a fully equipped emergency care facility that is separate, and distinct, from a hospital. These centers are staffed by qualified emergency physicians and provide full emergency care services including advanced life support and stabilization care in the event transfer for inpatient admission to an acute care facility *(Hospital)* is required.

Standard Reference Compendium means:

1. The United States Pharmacopoeia Drug Information;
2. The American Medical Association Drug Evaluation; and
3. The American Hospital Formulary Service Hospital Drug Information.

Subscriber means an Eligible Employee who meets and continues to meet all applicable eligibility requirements of the "*Eligibility Requirements for Subscribers*" sub-section of the "*Eligibility for Membership*" Section, who enrolls hereunder, and for whom the payment(s) required by FHCP has been received.

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

Telehealth *(Telemedicine)* Services means, for the purpose of this Certificate of Coverage, an interactive audio and video telecommunications system that permits real-time communications between a Member and a board-certified Physician or a Mental Health/Behavioral Health Provider. (See the *"Covered Medical Services"* and the *"Exclusions and Limitations"* Sections.*)*

Tertiary Care means specialized care provided by a specialized facility with specialty technology, tools, and medical staff. This is a type of care one might seek when other, typical approaches in medicine are insufficient for the diagnosis and/or treatment of a medical condition. Persons with a rare disease, birth defect, or a complex injury are all types of patients seen by these specialty tertiary programs. As aliments and conditions can affect any part of the body, tertiary physicians may therefore be specialty trained in any area of human physiology.

Triple Option Plan means a Plan under the Group that allows Plan Members to have benefits for, and access to, appropriate licensed health care providers who are recognized for payment under this Certificate of Coverage and who are:

1. Level 1– HMO Contracted Providers;
2. Level 2 – Providers in the Expanded Provider Network (EPN); and
3. Level 3 – Non-Contracted Providers

This type of Group Plan also allows Members to access any HMO *(Level 1)*, EPN *(Level 2),* or Non-Contracted Specialist *(Level 3)* without the need of a Prior Authorization by a Primary Care Physician and/or FHCP. The financial responsibility of the Member will be dependent upon the Level *(1, 2, or 3)* status of the Health Care Provider who rendered the service(s). See your Triple Option Plan and "*Summary of Benefits and Coverage"* and *"Schedule of Benefits"* for additional information regarding benefits including applicable copayments, coinsurance, deductibles, and/or balance billings as well as any special access and/or limitation rules.

Note: All of the provisions of this Certificate of Coverage still apply to Member's with Triple Option Group Plans.

United States Preventive Service Task Force (USPSTF) means an independent, volunteer, group of Physicians and other clinicians with expertise in prevention and evidence-based medicine. This group makes recommendations about clinical preventive services such as screenings, counseling, or preventive medications to improve the health of all Americans.

Urgent Care means medical care needed right away because of an illness, injury, or condition that was not expected or anticipated. The patient's health is not in serious jeopardy or danger and because of the situation. However, it is not reasonable for the patient to wait until care can be obtained from the patient's Primary Care Physician or other Contracted Provider.

Urgent Care Center means a facility properly licensed that:

1. Is available to provide Services to patients at least 60 hours per week with at least twenty-five *(25)* of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday;
2. Posts instructions for individuals seeking Health Care Services, in a conspicuous public place, as to where to obtain such Services when the Urgent Care Center is closed;
3. Employs or contracts with at least one or more Board-Certified or Board-Eligible Physicians and Registered Nurses (RNs) who are physically present during all hours of operation. Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children; and
4. Maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations.

For purposes of this Group Plan and Certificate of Coverage, an Urgent Care Center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility, or Rehabilitation Facility.

Waiting Period means the period of time specified on the Group Application, if any, which must follow the date an individual is initially employed by the Group before such individual may become a Member.

Zygote Intrafallopian Transfer (ZIFT) means a process in which an egg is fertilized in the laboratory and the result zygote is transferred to the fallopian tube at the pro-nuclear stage (before cell division takes place). The eggs are retrieved and fertilized on one day and the zygote is transferred the following day. **This service is excluded.** *(*See the *"Exclusions and Limitations"* Section*.)*

Section 2: Eligibility for Membership

Because this is Group coverage eligibility for Membership is tied to the individual's relationship with the Employer who establishes the Group Plan. The Employer will establish each employee or other individual who is eligible to participate in the Group Plan. Each employee or other individual who meets and continues to meet the Group's eligibility requirements shall be entitled to apply to become a Member of FHCP. Such eligibility requirements shall be binding upon the Group and the Member and no change in such requirements shall be permitted unless the Group notifies FHCP of the change and FHCP has agreed, in writing, to the change in advance; or such change is the result of State and/or Federal regulatory requirements.

Eligibility Requirements for Subscribers

To be an Eligible Subscriber, a person must be a bona fide employee of the Group and must meet each of the following requirements:

1. The employee must maintain his/her primary residence in the Group Plan Service Area or be regularly employed in the Group Plan Service Area;
2. The employee must have completed any applicable Waiting Period set forth by the Employer; and
3. The employee must meet any other applicable eligibility requirement(s) set forth on the Group Application / Contract or in the Group Plan.

This Subscriber eligibility class may be modified, and may be expanded to include:

1. Retired employees;
2. Employees of affiliated or subsidiary companies of the Group, provided such companies and the Group are under common control; and
3. Other individuals as determined by FHCP and the Group.

Unless mandated under State and/or Federal regulatory requirements, any expansion of the Subscriber eligibility class must be approved by FHCP and the Group, in writing, prior to such expansion.

Eligibility Requirements for Dependents

An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under this Certificate of Coverage. Except when mandated by State and/or Federal regulations, the EMPLOYER will determine what *(if any)* specific Dependent coverage is offered under the Group Plan.

1. The Subscriber's spouse under a legally valid existing marriage;
2. The Subscriber's Domestic Partner who meets the following criteria:
    a. Is in a mutual and committed relationship with the Subscriber;
    b. Shares joint responsibility for the household;
    c. Is at least 18 years of age;
    d. Is not legally married to someone else;
    e. Is not related to the Subscriber by blood;
    f. Is residing with the Subscriber not for the sole purpose of obtaining insurance;
    g. Who shares financial responsibility with the Subscriber; and
    h. Is mentally competent to consent to *(enter into)* a contract.
3. The Subscriber's natural, newborn, adopted, or stepchild(ren) *(or a child for whom the Subscriber has been court-appointed as legal guardian or legal custodian)* who is maintaining his or her primary residence in the Service Area, and who:
    a. Is under the age of 26 or is still within the Calendar Year in which he or she reaches age 26; or
    b. Has reached the end of the Calendar Year in which he or she becomes 26, but has not reached the end of the Calendar Year in which he or she becomes 30 and who:
        i. Is unmarried and does not have a dependent;
        ii. Is a Florida resident or a full-time or part-time student;
        iii. Is not enrolled in any other health coverage policy or plan; and
        iv. Is not entitled to benefits under Title XVIII of the Social Security Act unless the child is a handicapped dependent child.
    c. In the case of a handicapped dependent child, such child is eligible to continue coverage, beyond the limiting age of 30, as a Covered Dependent if the dependent child is:
        i. Is dependent upon the policyholder or subscriber for support;
        ii. Otherwise eligible for coverage under the Group Plan;
        iii. Incapable of self-sustaining employment by reason of Intellectual Disability or physical handicap; and

iv. Chiefly dependent upon the Subscriber for support and maintenance provided that the symptoms or causes of the child's handicap existed prior to the child's 30th birthday.

This eligibility shall terminate on the last day of the month in which the dependent child no longer meets the requirements for extended eligibility.

4. The newborn child of a Covered Dependent child who has not reached the end of the Calendar Year in which he or she becomes 26. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child unless the Employee produces documentation that he/she has:

   a. Adopted the newborn child; or

   b. Is the court appointed legal guardian of the newborn child.

Note: If a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 26 obtains a dependent of their own *(e.g., through birth or adoption)*, such newborn child will not be eligible for this coverage and the Covered Dependent child will also lose his or her eligibility for this coverage.

It is the Subscriber's sole responsibility to establish that a child meets the applicable requirements for eligibility. Eligibility will terminate on the last day of the month in which the child no longer meets the eligibility criteria required to be an Eligible Dependent.

The Spouse of a Dependent child is not eligible for coverage.

Exception for Students on Medical Leave of Absence from School

A Covered Dependent child who is a full-time or part-time student at an accredited post-secondary institution, who takes a Physician certified medically necessary leave of absence from school, will still be considered a student for eligibility purposes under this Certificate of Coverage for the earlier of 12 months from the first day of the leave of absence or the date the Covered Dependent would otherwise no longer be eligible for coverage under this Certificate of Coverage.

Other Requirements/Rules Regarding Eligibility

1. A foster child (or other child) shall be eligible for insurance benefits in the event of a court ordered temporary or other custody of the insured PRIOR to the child's 18th birthday. *(Fla. Statute §627.6415(4))*

2. No individual whose Membership in FHCP has been terminated for cause (See the "*Termination of Individual Membership"* Section) shall be eligible to re-enroll in FHCP.

3. No person shall be refused enrollment or re-enrollment in FHCP because of race, color, creed, marital status, sex, age *(*except as provided in the *"Eligibility Requirements for Dependents"* sub-section above*),* health status including medical condition, claims experience, medical history, evidence of insurability *(including conditions arising out of domestic violence or participation in activities such as motorcycling, snowmobiling, etc.)*, disability , or any other health status related factor

deemed appropriate under Federal regulations. *(*Except as provided in the *"Eligibility Requirements for Dependents"* sub-section above.*)*

4. The Subscriber must complete the *"Group Health Employee Application/Change"* Form (available from their Employer). This Form must be completed within 30 days from the date a Dependent Member is no longer eligible for Membership. The Employer will then forward the completed Form to FHCP. If a Dependent fails to continue to meet each of FHCP's eligibility requirements, and such proper notification is not timely provided by the Subscriber to FHCP, FHCP shall have the right to retroactively terminate Membership of such Dependent to the date any such eligibility requirement was not met, and to recover an amount equal to the Allowance for Services and/or supplies provided following such date less any Premium received by FHCP for such Dependent for coverage after such date. Upon FHCP's request, the Subscriber shall provide proof, which is acceptable to FHCP, of a Dependent's continuing eligibility for Membership.
5. If the Group offers an alternative health benefits plan for Medicare eligible or retirees, and an individual elects to be covered under such plan, then such individual shall not be eligible for Membership.

Section 3: Enrollment and Effective Date of Coverage

Any individual who is not properly enrolled will not be eligible for Covered Services hereunder and FHCP shall have no obligation whatsoever with respect to such individual.

Eligible Employees and Eligible Dependents may apply for Membership upon completion and submission of documents approved by FHCP and submitted through his or her Employer. Membership eligibility is in accordance with the provisions set forth below.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

Initial Enrollment Period is the period of time during which an Eligible Employee or Eligible Dependent is first eligible to enroll. It starts on the Eligible Employee's or Eligible Dependent's initial date of eligibility and ends no less than 30 days later.

Annual Open Enrollment Period is an annual 30 day period occurring no less than 30 days prior to the Anniversary Date, during which each Eligible Employee is given an opportunity to select coverage from among the alternatives included in the Group's health benefit program.

Note: The Annual Open Enrollment Period may vary and may not apply to certain groups.

Special Enrollment Period is the 30-day period immediately following a special circumstance during which an Eligible Employee or Eligible Dependent may apply for Membership. Special circumstances are described in the "*Special Enrollment"* sub-section.

General Rules for Enrollment

1. All factual representations on the enrollment forms must be accurate and complete. Any false, incomplete, or misleading information provided during the enrollment process, or at any other time, may result, in addition to any other legal right(s) FHCP may have, in disqualification for, termination of, or rescission of Membership for cause.
2. FHCP shall not be required to provide coverage and/or benefits to any individual who would not have been entitled to Membership if FHCP had accurate and complete information been provided on a timely basis on the enrollment forms. In such cases, FHCP may require such individual, or an individual legally responsible for that individual, to reimburse FHCP for any such Covered Services provided or payments made by FHCP on behalf of such individual.

3. If the Group requires an individual to make a periodic financial contribution in order to be a Member, such individual shall have agreed in writing to make, and shall make, all required financial contributions.

Note: FHCP retains the right to request any additional information that may be required to determine eligibility.

Enrollment Forms / Electing Coverage

To apply for Membership, the Eligible Employee must:

1. Complete and submit, through his or her employer, a "*Group Health Employee Application/Change"* Form *(or equivalent)* to FHCP;
2. Provide any additional information needed to determine eligibility, if requested by FHCP;
3. Complete and submit within 60 days of enrollment a "*Coordination of Benefits"* Form;
4. Agree to pay his or her portion of the required Premium. In addition, agree to payment of any applicable copayment, coinsurance, and deductible; and
5. Complete and submit, through his or her employer, *a "Group Health Employee Application/Change"* Form to add or delete Dependents.

When making application for coverage, the Eligible Employee must elect one of the types of coverage available under the Group's program. Such types **may** include:

1. **Employee Only Coverage**. This type of coverage provides coverage for the Eligible Employee only;
2. **Employee/Spouse *(or if covered under the group Domestic Partner)* Coverage**. This provides coverage for the Eligible Employee and the employee's present lawful spouse only;
3. **Employee/Child(ren) Coverage**. This type of coverage provides coverage for the Eligible Employee and the employee's eligible child(ren) only; or
4. **Employee/Family Coverage**. This type of coverage provides coverage for the Eligible Employee and the employee's Eligible Dependents.

There may be additional Premium for each Dependent based on the coverage selected by the Group.

Employee Enrollment

1. An individual who is an Eligible Employee on the Group's Effective Date must enroll during the Initial Enrollment Period. The Eligible Employee shall become a Subscriber as of the Effective Date of the Group. Eligible Dependents may also be enrolled during the Initial Enrollment Period. In this instance, the Effective Date of coverage for an Eligible Dependent(s) shall be the same as the Subscriber's Effective Date.
2. An individual who becomes an Eligible Employee after the Effective Date of the Group (for example, newly hired employees) must enroll before or within the Employee's Initial Enrollment Period. The Effective Date of coverage for such individual shall be determined by the Employer. All coverage will begin on the 1st day of the month.

Note: An employee who is a newly Eligible Employee must enroll within his or her Initial Enrollment Period. An employee who has been covered under another health benefit plan established and maintained by the Employer, and who now wants to change to this Group Plan, must enroll for such coverage change during the Special Enrollment Period if he or she qualifies. If an employee does not enroll for coverage under this Group Plan during his or her Initial Enrollment Period or as a Special Enrollee, he or she will be considered a Late Enrollee.

Dependent Enrollment

When applicable under the Group Plan, an individual may be added upon becoming an Eligible Dependent of a Subscriber in accordance with provisions described in the "*Eligibility Requirements for Dependents"* sub-section.

1. **Newborn Child**: To enroll a newborn child who is an Eligible Dependent, the Subscriber must submit a "*Group Health Employee Application/ Change"* Form that is available through their Employer prior to or during the 60-day period immediately following the date of birth. The Employer will forward the completed Form to FHCP. The Effective Date of coverage for a newborn child shall be the date of birth.

   FHCP must be notified, in writing, within 60 days after the birth. If notice is given within 30 days of the date of birth no additional Premium will be charged for coverage of the newborn child for 30 days after the birth of the child. If notice is not received within 30 days of the date of birth, FHCP will charge the applicable Premium from the date of birth. The applicable Premium for the child will be charged after the initial 60-day period in either case. Coverage will be denied if notice is not given within 60 days of the date of birth of the newborn child. However, such newborn child may be enrolled during the next Annual Open Enrollment Period.

Note: Coverage for a newborn child of a Covered Dependent child who has not reached the end of the Calendar Year in which he or she becomes 26 will automatically terminate 18 months after the birth of the newborn child unless the Employee produces documentation that he/she:

a. Adopted the newborn child; or

b. Is the court appointed legal guardian or legal custodian of the newborn child.

A Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 26, and obtains a dependent of their own *(e.g., through birth or adoption)*, will no longer be eligible for this coverage for themselves or their newborn or adopted child.

2. **Adopted Newborn Child**: To enroll an adopted newborn child, the Subscriber must complete a "*Group Health Employee Application/ Change"* Form*,* available through their Employer, prior to or during the 60-day period immediately following the date of adoption. The Employer will forward the completed Form to FHCP and the Subscriber must pay the additional Premium, if any. The effective date of coverage for an adopted newborn child eligible for Membership shall be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Member prior to the birth of such child, whether or not such agreement is enforceable; or,

   If the adopted newborn child is enrolled within 30 days immediately following the date of adoption, Premium will not be charged for the first 30 days of coverage. If the adopted newborn child is enrolled after 30 days of the date of adoption, Premium will be charged from the moment of birth. Coverage will be denied if notice is not given within 60 days of the date of birth of the adopted newborn child. However, such adopted newborn child may be enrolled during the next Annual Open Enrollment Period.

   If the adopted newborn child is not ultimately placed in the residence of the Subscriber, there shall be no coverage for the adopted newborn child under the Group Plan. It is the responsibility of the Subscriber to notify FHCP within ten (10) calendar days if the adopted newborn child is not placed in the residence of the Subscriber.

3. **Adopted Child**: To enroll an adopted child the Subscriber must complete a "*Group Health Employee Application/Change"* Form*,* available through their Employer, prior to or during the 60-day period immediately following the date of adoption. The Employer will forward the completed Form to FHCP and the Subscriber must pay the additional Premium, if any. The Effective Date for an adopted child *(other than an adopted newborn child)* shall be the date such adopted child is placed in the residence of the Member in compliance with Florida law. If the adopted child is enrolled within 30 days immediately following the date of adoption, Premium will not be charged for the first 30 days of coverage. If the adopted child is enrolled after 30 days of the date of adoption, Premium will be charged from the date such adopted child is placed in the residence of the Member.

   For all children covered as adopted children, if the final decree of adoption is not issued, coverage shall not be continued for the proposed adopted child under the Group Plan. Proof of final adoption must be submitted to FHCP. It is the responsibility of the Subscriber to notify their Employer and FHCP if the adoption does not take place. Upon receipt of this notification, FHCP will terminate the coverage of the child on the last day of the month following our receipt of your written notice.

4. **Marital Status**: A Subscriber may apply for coverage of an Eligible Dependent due to marriage. To apply for coverage, the Subscriber must notify their Employer and

complete the "*Group Health Employee Application / Change"* Form, available through their Employer, within 60 days of the marriage. The Employer will forward the completed Form to FHCP and the Subscriber must pay the additional premium if any. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of marriage is the date of the marriage.

5. **Court Order**: A Subscriber may apply for coverage for an Eligible Dependent under the Group Plan outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under the Subscriber's plan. To apply for coverage, the Subscriber must complete the "*Group Health Employee Application / Change"* Form*,* available through their Employer, within 60 days of the court order. The Employer will forward the completed Form to FHCP and the Subscriber must pay the additional Premium, if any. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court order or the 1st day of the following month.

6. **Foster Child**: A Subscriber may apply for coverage for a Foster Child under the Group Plan outside of the Initial Enrollment Period in the event of a court ordered temporary or other custody appointed to the Subscriber PRIOR to the child's 18th birthday. To apply for coverage, the Subscriber must complete the "*Group Health Employee Application/ Change"* Form*,* available through their Employer, within 60 days of the court order. The Employer will forward the completed Form to FHCP and the Subscriber must pay the additional Premium if any. The effective date of coverage for an Eligible Foster child who is enrolled as the result of a court ordered temporary or other custody appointment is the date of placement by the court or custody appointment agency. It is the responsibility of the Subscriber to notify their Employer and FHCP when the temporary or other custody appointment is terminated. Upon receipt of this notification, FHCP will terminate the coverage of the child on the date the Subscriber no longer has custody.

7. **Domestic Partner:** An Individual cannot apply for coverage of a Domestic Partner for the sole purpose of obtaining insurance. The Domestic Partner must meet all of the other criteria set forth under "*Eligibility Requirements for Dependents"* sub-section of the *"Eligibility for Membership"* Section. To apply for coverage, the Subscriber must complete the "*Group Health Employee Application / Change*" Form, available through the Employer or FHCP. The Subscriber must pay the additional premium, if any. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of becoming a qualified Domestic Partner is the date FHCP receives, reviews, and approves the *"Group Health Employee Application / Change"* Form, available through the Employer or FHCP.

Annual Open Enrollment

Eligible Employees and/or, when applicable under the Group Plan, Eligible Dependents who did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for coverage during an Annual Open Enrollment Period. The Eligible

Employee may enroll by completing their Employer's "Group Enrollment Process" during the Annual Open Enrollment Period.

The Effective Date of Coverage for an Eligible Employee and any Eligible Dependent(s) will be the Group Plan Anniversary Date.

Eligible Employees who do not enroll or change their coverage selection during the Annual Open Enrollment Period must wait until the next Annual Open Enrollment Period, unless the Eligible Employee is enrolled due to a special circumstance as outlined in the "*Special Enrollment"* sub-section.

Note: The Annual Open Enrollment Period may vary and may not apply to certain groups.

Special Enrollment

An Eligible Employee and/or, when applicable under the Group Plan, the Employee's Eligible Dependent(s) may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment qualifying event. To apply for coverage, the Eligible Employee and/or the Employee's Eligible Dependent(s) must complete the "*Group Health Employee Application/Change"* Form*,* available through their Employer, within the time periods noted below for each Special Enrollment Event. The Employer will forward the completed Form to FHCP.

An Eligible Employee and/or, when applicable, the Employee's Eligible Dependent(s) may apply for coverage if one of the following special enrollment qualifying events occurs and the appropriate "*Group Health Employee Application/Change"* Form is submitted to FHCP within the indicated time periods:

1. If an Eligible Employee loses coverage under another group health benefit plan *(As an employee or dependent)*, or coverage under other health insurance *(Except in the case of loss of coverage under a Children's Health Insurance Program* (CHIP), or Medicaid *see #3 below),* or COBRA continuation coverage that the Eligible Employee was covered under at the time of initial enrollment provided that:
    a. When offered coverage under this plan at the time of initial eligibility, the Eligible Employee stated, in writing, that coverage under another group health plan or health insurance coverage was the reason for declining enrollment; and
    b. The Eligible Employee lost their other coverage under a group health benefit plan or health insurance coverage (*except in the case of loss of coverage under a CHIP or Medicaid, see #3 below)* as a result of termination of employment, reduction in the number of hours they work, reaching or exceeding the maximum lifetime of all benefits under other health coverage, exhaustion of COBRA or Florida Continuation, the employer ceased offering group health coverage, death of their spouse, divorce, legal separation, or employer contributions toward such coverage was terminated; and

c. The Eligible Employee then submits the "*Group Health Employee Application/Change"* Form to their Employer within 30 days of the date their coverage was terminated. The Employer will forward the completed Form to FHCP;

Or

2. If when offered coverage under this plan at the time of initial eligibility, the Eligible Employee stated, in writing, that coverage under another group health plan or health insurance coverage was the reason for declining enrollment; **and** the Eligible Employee gets married or obtains a dependent through birth, adoption or placement in anticipation of adoption **and** the Eligible Employee submits the "*Group Health Employee* A*pplication/Change"* Form to their Employer within 60 days of the date of the event. The Employer will forward the completed Form to FHCP;

   Or

3. If the Eligible Employee or their Eligible Dependent(s) lose coverage under CHIP or Medicaid due to loss of eligibility for such coverage or become eligible for the optional State Premium Assistance Program and the Eligible Employee submits the "*Group Health Employee Application/ Change"* Form to their Employer within 60 days of the date such coverage was terminated or the date the Eligible Employee becomes eligible for the optional state premium assistance program. The Employer will forward the completed Form to FHCP.

Special Circumstances: An Eligible Employee may apply for coverage due to the following special circumstances: birth of a child or placement for adoption, or marriage. Eligible Dependents may be enrolled at the time an Eligible Employee enrolls. To apply for coverage, the Eligible Employee must complete the "*Group Health Employee Application/Change"* Form, available through their Employer, and return the Form to their Employer within 60 days of the special circumstance. The Employer will forward the completed Form to FHCP. The Effective Date of coverage for an Eligible Employee and any other Dependent(s) who are enrolled as a result of birth, adoption, placement for adoption, or marriage is the date of the event.

If an Eligible Employee does not enroll for coverage under this Group Plan during his or her Initial Enrollment Period or Annual Enrollment Period as a Special Enrollee, he or she will be considered a Late Enrollee. If an Eligible Employee does not enroll or change their coverage selection during the Special Enrollment Period he or she must wait until the next Annual Open Enrollment Period.

Other Requirements/Rules Regarding Enrollment

All the following additional requirements must be met in order for an individual to be enrolled:

1. FHCP must be properly notified on a timely basis by the Group of any changes in the Member's status. Additionally, the Group shall immediately forward any "*Group Health Employee Application/ Change"* Form submitted by a Subscriber to FHCP;
2. Entitlement to Covered Services is subject to the timely receipt by FHCP from the Group of the monthly Premium on behalf of Eligible Employees and their Dependents enrolled as Members of FHCP; and
3. Subscribers are responsible for adding and deleting Dependents in accordance with FHCP's requirements and on a timely basis. Subscribers must advise the Group immediately in the event a Dependent no longer meets the eligibility requirements by submitting a "*Group Health Employee Application/Change"* Form to the Group. FHCP is not responsible for providing Covered Services for any individual who should not have been added or who should have been deleted. The Group and the Subscriber are liable to FHCP for any such Covered Services provided by FHCP.

Note: Any Employer may elect to notify FHCP of enrollment eligibility data via an "834" electronic file feed.

Section 4: Termination of Individual Membership

Termination of Subscriber Membership

A Subscriber's Membership will automatically terminate at 12:01 a.m. on the date:

1. The Group Plan terminates;
2. The Subscriber becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
3. The Employer fails to pay the applicable premium or the Subscriber otherwise fails to continue to meet each of the eligibility requirements specified by FHCP or the Group; or
4. The Subscriber's Membership is terminated for cause. *(See the "Termination of Individual Membership for Cause" sub-section.*)

Termination of Dependent Membership

A Dependent's Membership will automatically terminate at 12:01 a.m. on the date:

1. The Group Plan terminates;
2. His or her Subscriber's Membership terminates for any reason;
3. The Dependent becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
4. The Dependent otherwise fails to continue to meet each of the eligibility requirements; or
    a. As further clarification for purposes of this sub-section, a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 26, but who has not reached the end of the Calendar Year in which the Covered Dependent becomes 30 will lose coverage if the covered Dependent incurs any of the following:
        i. Marriage;
        ii. No longer resides in Florida or is no longer a full-time or part-time student;
        iii. Obtains a dependent *(e.g., through birth or adoption)*;
        iv. Obtains other coverage;
        v. A court order, including a qualified medical child support order, covering a dependent child is no longer in effect; or
        vi. A change in marital status that makes a person ineligible under the terms of the Group Plan.
5. The Dependent's Membership is terminated for cause. (S*ee the "Termination of Individual Membership for Cause" sub-section.)*

Termination of Individual Membership for Cause

If, in FHCP's opinion, any of the following events occur, FHCP may terminate an Individual's Membership for cause:

1. Disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative behavior to the extent that such Member's continued Membership in FHCP impairs FHCP's ability to provide coverage and/or benefits or to arrange for the delivery of Health Care Services to such Member or to other Members. Prior to dis-enrolling a Member for any of the above reasons, FHCP will:
   a. Make a reasonable effort to resolve the problem presented by the Member, including the use or attempted use of FHCP's Complaint and Grievance Process (Refer to the "*Complaint*, *Grievance and Appeal Processes" S*ection); and
   b. Ascertain, to the extent possible, that the Member's behavior is not related to the use of medical Services or mental illness; and
   c. Document the problems encountered, efforts made to resolve the problems, and any of the Member's medical conditions involved.
2. The knowing misrepresentation, omission, or the giving of false information on the Individual "*Group Health Employee Application/ Change"* Form or other forms completed for FHCP, by or on behalf of the Member;
3. Fraud, material misrepresentation, or omission in applying for Membership or in requesting the receipt of Covered Services;
4. Misuse of the Membership Card;
5. The Member no longer lives, resides, or works in the Service Area; or
6. A Dependent reaches the limiting age as specified in the *"Eligibility for Membership"* and *"Enrollment and Effective Date of Coverage"* Sections.

Any termination made under the provisions stated above is subject to review in accordance with the *"Complaint, Grievance and Appeal Processes"* Section.

Limit on Certain Defenses Relative to a Misstatement in the Application, after two *(2)* years from the issue date, only fraudulent misstatements in the application may be utilized to void the policy or deny any claim for loss incurred or disability starting after the 2-year period.

Notice of Individual Member Termination

Notice by FHCP: (***NOTE:*** *except for termination of the Group Plan, or for nonpayment of Premium, or as a result of termination of eligibility*.) If an individual's Membership terminates for *"cause,"* FHCP shall notify such Member and the Group, in writing, at the respective addresses then on file with FHCP, **at least 45 days prior to the date of termination**. Such notice to Members who are Dependents may be made through such Dependent's Subscriber. This notice shall state the exact reason(s) for the individual's termination *(Items 1 through 6 listed above)* and will include the individual's right to, and instructions for, filing an appeal of the termination to FHCP. (See the *"Complaint, Grievance, and Appeal Processes"* Section.)

Rescission of Eligibility

Termination for Non-payment of Premiums or Individual Contribution:

In the event an individual's Membership terminates as the result of non-payment of premium or non-payment of individual contributions, FHCP shall notify such Member and the Group in writing, at the respective addresses then on file with FHCP. Such notice will be issued at the conclusion of the 10-day grace period and such notice shall be mailed prior to 45 days after the date the premium was due (see "Glossary" Section) and shall state the effective date of the termination.

The date of termination shall be no earlier the midnight of the date that the premium was due. The notice will also include individual's right to, and instructions for, filing an appeal of the termination to FHCP. (See the *"Complaint, Grievance and Appeal Processes"* Section.)

NOTE: Also see the "*Termination of Subscriber Membership*" sub-section above.

Retroactive Individual Termination for Cause

When the termination of an individual is NOT the result of termination of the Group, Non-payment of premiums, or individual contributions, but for cause*(s)* as listed in this Section under *"Termination of Individual Membership for Cause,"* the individual's termination of Membership may have a retro-active effect. Circumstances that can result in a retro-active termination are:

- The knowing misrepresentation, omission, or the giving of false information on the Individual "*Group Health Employee Application / Change"* Form, or other Forms completed for FHCP, by or on behalf of the Member;
- A Dependent reaches the limiting age as specified in the *"Eligibility for Membership"* and *"Enrollment and Effective Date of Coverage"* Sections; or
- Fraud, material misrepresentation, or omission in applying for Membership or in requesting the receipt of Covered Services.

FHCP shall notify such Member and the Group, in writing, at the respective addresses then on file with FHCP. Such notice to Members who are Dependents may be made through such Dependent's Subscriber. This notice will contain the exact reason(s) for the Individual's termination and will include the individual's right to, and instructions for, filing an appeal of the termination to FHCP's *(*see the *"Complaint, Grievance and Appeal Processes"* Section*.)*

Responsibilities of FHCP upon Termination of an Individual's Membership

Upon termination of an individual's Membership for any reason, FHCP shall have no further liability or responsibility with respect to such individual, except as otherwise specifically set forth in this Certificate of Coverage.

Note: Any Employer may elect to notify FHCP of termination of enrollment data via an "834" electronic file feed.

Section 5: Financial Obligations of the Member

Copayments, Coinsurance and Deductible

Each Member is obligated to pay the Copayment, Coinsurance, and/or Deductible amounts, if applicable, set forth in the "*Summary of Benefits and Coverage"* and *"Schedule of Benefits."*

The Subscriber shall also be responsible for the payment of all Copayments, Coinsurance, and/or Deductible, if applicable, for Covered Services with respect to every individual enrolled as his or her Covered Dependent.

The individual Copayment, Coinsurance, or Deductible for a newborn child or adopted newborn child in connection with the newborn's initial Hospital stay following birth will apply. All such payment obligations are due and payable as they are incurred and are paid directly to the health care provider.

The Copayment, fixed dollar amounts, are payable to the Provider regardless of the allowed amount for the services rendered. Coinsurance is a variable amount the Member owes to the Provider and is based upon a percentage of the allowed amount for the service(s) rendered.

Non-Covered Services

Members are responsible for the payment of charges for Non-Covered Services **and** for the payment of charges in excess of any maximum benefit limitation set forth in the "*Summary of Benefits and Coverage"* and *"Schedule of Benefits."*

Contributions

The Subscriber is responsible for any Premium contribution amount required by the Group, if any.

Maximum Out-of-Pocket

Total Copayments, Coinsurance, and Deductible, if applicable, in any Calendar Year *(Or if applicable Contract Year)* shall not exceed the amount indicated in your "*Summary of Benefits and Coverage"* and *"Schedule of Benefits."* This amount in no event shall exceed twice the total annual Subscription Fees which a Subscriber *(or, if there are Covered Dependents*, *the Subscriber and his or her Dependents)* would be required to pay if such individual(s) were enrolled under an option with no Copayments, Coinsurance, or Deductible, if applicable. Thereafter, Covered Services will be provided for that Member at no cost to them *(No Copayment, Coinsurance, or Deductible)* for the remainder of the Calendar (*Or if applicable Contract)* Year.

Note: The applicable Maximum Out-of-Pocket period *(also referred to as Plan Benefit Period (PBP) or Plan Contract Period (PCP))* for the Group Plan, calendar year or contract year, will appear on your *"Summary of Benefits and Coverage"* and *"Schedule of Benefits."*

The following costs **do not apply** to your Maximum Out-of-Pocket:

1. Plan Premiums;
2. Balance Billing for out-of-network providers under a Point-of-Service or Triple Option plan;
3. Costs for non-covered services or supplies. (See the "*Exclusions & Limitations"* Section.);
4. Cost for non-covered prescription drugs or supplies (See the *"Prescription Drug Coverage"* Section.); and
5. Drug Cost-sharing assistance through manufacturer discount plans, manufacturer coupons, foundations, and/or other third-party assistance.

BALANCE BILLING PROTECTION:

Federal and State law provides balance billing in certain circumstances.

Members whose claims were processed by FHCP at the Maximum HMO benefit level, including services rendered related to emergency or urgently needed care, have balance billing protection against the provider of the service(s). Such services include but are not limited to emergency transportation including air ambulance if: The travel distance / location is inaccessible by ground transport; Speed in excess of ground transport if speed is critical; or The distance involved in getting you to the nearest Hospital that can provide care is too far for medical safety as determined by FHCP.

Further, Members have balance billing protection for non-emergency services performed by the following types of Non-Contracted Providers at Contracted Provider Facilities:

1. Emergency Medicine;
2. Anesthesia;
3. Pathology;
4. Radiology;
5. Laboratory;
6. Assistant Surgeon;
7. Hospitalist;
8. Intensivist Services or;
9. Other items and services as determined by the Secretary of the United States Department of Health and Human Services.

For non-emergency services by the above listed Non-Contracted Providers performed at Contracted Provider Facilities your cost share will not be more than the amount you may have paid for the same services had they been performed by an in-network Provider. Additionally, your out-of-pocket expenses will apply as if the services were in-network. For other Non-Contracted Providers at Contracted Provider facilities, those Non-Contracted Providers may not balance bill Members unless the Member gives written consent and forfeits their rights, or those services are elective (non-emergency related).

NOTE: Members with a Point-of-Service or Triple Option Plan, when you utilize a Contracted Provider your claim(s) will be processed at the Maximum, HMO, Benefit Level minus applicable HMO Copayment, Coinsurance, and/or Deductible. Utilization of Non-Contracted Providers, except for emergency or urgently needed care and those above listed services at Contracted Provider Facilities, may result in a higher financial responsibility on your part; higher Copayment, Coinsurance and/or Deductible, plus any applicable balance billing.

Section 6: Extension of Benefits/Certification of Creditable Coverage

Extension of Benefits

In the event the entire Group Plan is terminated coverage shall end as of the termination date. FHCP will not provide coverage or benefits for any service rendered on or after the termination date, except as set forth below.

Note: It is the Member's responsibility to provide acceptable documentation to FHCP that the Member is entitled to an extension of benefits.

1. In the event, a Member is totally disabled on the termination date of the Group Plan as a result of a specific accident or illness incurred while the Member was covered under the Group Plan, as determined by FHCP, FHCP will provide a limited extension of benefits for the disabled Member only. This extension of benefits is for Covered Services necessary to treat the disabling condition only. This extension of benefits will only continue as long as the disability is continuous and uninterrupted. However, in any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the Group Plan.

   For purposes of this Section, a person is totally disabled only if, in the opinion of FHCP, the Member is unable to work at any gainful job for which the Member is suited by education, training, or experience, and the Member requires regular care and attendance by a Physician.

   This would also apply to a Member who, although not engaged in an occupation *(e.g., a student*, *non-working spouse, or children*), is not able to perform the normal day-to-day activities which they would otherwise be able to perform.

2. In the event, a Member is pregnant as of the termination date of the Group Plan, FHCP will provide a limited extension of the maternity expense benefits, provided the pregnancy commenced while the pregnant Member was covered by FHCP. This extension of benefits is for Covered Services necessary to treat the pregnancy only. This extension of benefits will automatically terminate on the date of the birth of the child. This extension of benefits is not predicated upon the Member being totally disabled.

FHCP is not required to provide an extension of benefits if this entire Group Plan is terminated by FHCP based upon any event referred to in §641.3922(7)(a) through (e) *Florida Statutes*. This includes; If the coverage was terminated for cause, due to disruptive, unruly, abusive, or uncooperative behavior to the extent that such Covered Person’s continued Membership in the Group Plan impairs FHCP’s ability to administer this Plan or to arrange for delivery of health care services to such covered persons; If the Covered Person committed fraud or intentional misrepresentation or omission in applying for any benefits under this Group Plan; or If the Covered Person has left FHCP’s Service

Area *(Brevard, Flagler, Seminole, St. Johns, and Volusia Counties)* with the intent to relocate or establish a new residence.

Certification of Creditable Coverage

In the event Membership terminates for any reason, FHCP will issue a written Certification of Creditable Coverage to the Member.

This *"Certificate of Creditable Coverage"* will indicate the period of time the Member was enrolled with FHCP.

Members may request another Certification of Creditable Coverage within a 24-month period after termination of coverage.

The succeeding carrier will be responsible for determining if the FHCP coverage meets the qualifying creditable coverage guidelines *(e.g., no more than a 63-day break in coverage)*.

Section 7: Medicare Secondary Payer Provisions

When a Member becomes covered under Medicare and continues to be eligible and covered under the Group Plan, FHCP's coverage hereunder shall be primary and the Medicare benefits shall be secondary, but only to the extent required by law. In all other instances, FHCP's coverage hereunder shall be secondary to any Medicare benefits. To the extent FHCP is primary payer, claims for Covered Services should be filed with FHCP first.

Under Medicare, the Group MAY NOT offer, subsidize, procure, or provide a Medicare supplement insurance policy to such individual. Also, the Group MAY NOT induce such individual to decline or terminate his or her group health coverage and elect Medicare as his or her primary payer.

Working Elderly

A Member who becomes 65 or who becomes eligible for Medicare due to End Stage Renal Disease (ESRD) should notify the Group.

Individuals with End Stage Renal Disease

For a Member who is entitled to Medicare coverage because of ESRD, FHCP will provide group health coverage on a primary basis for 30 months beginning with the earlier of:

1. The month in which the individual became entitled to Medicare Part A ESRD benefits; or
2. The first month in which the individual would have been entitled to Medicare Part A ESRD benefits if a timely application had been made.

If Medicare was primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary *(i.e., persons entitled due to disability whose employer has less than 100 employees, retirees, and/or their spouses over the age of 65).* Also, if Group health coverage was primary prior to ESRD entitlement, then the Group will remain primary for the ESRD coordination period. For individuals eligible for Medicare due to ESRD, FHCP will provide group health coverage, as set forth herein, on a primary basis for 30 months.

Disabled Active Individuals

FHCP will provide primary coverage to Members, if:

1. The Group is a part of a health plan that has covered employees of at least one employee of 100 or more full-time or part-time employees on 50% or more of its regular business days during the previous Calendar Year; and
2. The Members are entitled to Medicare coverage because of disability *(unless they have ESRD).*

Primary coverage under the Group Plan is pursuant to the following terms:

1. For a Member, FHCP will provide group health coverage, as set forth in the Group Plan, on a primary basis during any month in which that individual is entitled to Medicare coverage because of disability;
2. Individual entitlement to primary coverage under this sub-section will terminate automatically when:
   a. The individual turns 65 years of age; or
   b. The individual qualifies for Medicare coverage because of disability; or
   c. The individual elects Medicare as the primary payer. Coverage will terminate as of the day of such election.

   Under Medicare, the Group MAY NOT offer, subsidize, procure, or provide a Medicare supplement policy to such individual or induce such individual to decline or terminate his or her group health coverage and elect Medicare as his or her primary payer; and
3. Entitlement of the Member to primary coverage under this sub-section will terminate automatically if the Member no longer qualifies as such under applicable Medicare regulations and instructions. The Group shall notify FHCP, without delay, of any such change in status.

Miscellaneous

1. This Section shall be subject to, modified if necessary to conform to or comply with, and interpreted with reference to the requirements of Federal Statutory and Regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under the Group Plan.
2. FHCP shall not be liable to the Group or to any individual covered under the Group Plan due to any nonpayment of primary benefits resulting from any failure of performance of the Group's obligations as set forth in this Section.
3. If FHCP should elect to make primary payments covering Services rendered to a Member described in this Section in a period prior to receipt of the information required by the terms of this Section, FHCP may require the Group to reimburse FHCP for such payments. Alternatively, FHCP may require the Group to pay the rate differential that resulted from the Group's failure to provide FHCP with the required information in a timely manner.

Section 8: Continuation of Coverage under COBRA

Federal continuation of coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, also known as Section 4980B of the *Internal Revenue Code* of 1986, may apply to the Group *(Employers with 20 or more employees)*. If COBRA applies to the Group, a Member previously covered under the Group Plan, may be entitled to continue his or her group health coverage for a limited period of time, if the Member meets the applicable requirements, makes a timely election, and pays the proper Premium.

A Member must contact the Group to determine if he/she is entitled to COBRA continuation of coverage.

The Group is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify all Subscribers and Dependents of their rights under COBRA. If the Group or the Member fails to meet its obligations under COBRA and the Group Plan, FHCP shall not be liable for any claims incurred by the Member after his/her termination of coverage.

Solely for the convenience of the Group and Members, a summary of COBRA rights of a Member and the general conditions for a Member's qualification for COBRA continuation coverage is provided below. **This summary is not meant as a representation that any of the COBRA obligations of the Group are met by establishing the Group Plan. The duty to meet such obligations remains with the Group.**

If COBRA applies to the Group and the Member is eligible for such coverage, Members may elect to continue their group health coverage if they qualify under one of the following circumstances:

1. If coverage would otherwise be lost due to the death of a Subscriber, the surviving Dependent(s) may qualify to elect to continue group health coverage for a period of time not to exceed 36 months from the date of death;
2. A Dependent who would otherwise lose coverage due to a divorce or legal separation from a Subscriber, may qualify to elect to continue group health coverage for a period of time not to exceed 36 months from the date of divorce or legal separation;
3. A Dependent of a Subscriber, who would otherwise lose coverage due to the Subscriber's entitlement to Medicare, may qualify to elect to continue group health coverage for a period not to exceed 36 months from the date the Subscriber first becomes entitled to Medicare;
4. Children, who are Dependents of a Subscriber, who would otherwise lose coverage due to a failure to meet FHCP's eligibility requirements *(e.g., exceeding the limiting age)*, may qualify to elect to continue group health coverage for a period not to exceed 36 months from the date the child ceased to meet such eligibility requirements;
5. Subscribers and Dependents may qualify to elect to continue group health coverage:

a. If coverage would otherwise be lost due to termination of employment with the Group *(Other than for reasons of gross misconduct)* or due to a reduction in hours of employment with the Group. This continuation of coverage may continue for a period not to exceed 18 months from the date of termination or reduction in hours.

b. If the Member is totally disabled *(As defined by the Social Security Administration)* at the time of the Subscriber's termination, reduction in hours, or within the first 60 days of COBRA continuation of coverage, an extension of coverage of up to 11 additional months may be available *(29 months total)* if all notification and eligibility requirements have been met. Extension of coverage 11 additional months will not be provided if the Member fails to provide the Group with a copy of the "*Determination of Disability*" letter from the Social Security Administration within 60 days of the date of the determination of disability. The "*Determination of Disability*" letter must be provided to the Group prior to the end of the 18-month COBRA continuation period. If the extension of coverage for the 11 additional months is granted, the extension is also applicable to all non-disabled family members who were entitled to COBRA coverage during the 18 months of coverage.

6. If a Member is receiving continuation of coverage under paragraph 5 above, such coverage may continue for a period longer than the time stipulated in that paragraph if an event that would otherwise have entitled the Member to COBRA continuation of coverage *(For example, divorce, legal separation, or death)* later occurs. But in no event will the Member receive coverage beyond 36 months from the event that originally made him or her eligible for coverage; or

7. If a bankruptcy or other proceeding under Title 11 of the United States Code commences with respect to the Group, continuation rights shall be provided to the Member to the extent required under COBRA.

In order for the group health coverage to continue pursuant to COBRA, the following conditions must be met:

1. If coverage would be lost due to:

   a. A reduction in hours or termination of employment *(For reasons other than gross misconduct),* the Group must notify the Subscriber and Dependents of their continuation of coverage rights under COBRA within 14 days of the termination of employment or reduction in hours causing a loss of coverage; or

   b. Medicare entitlement, divorce, legal separation, or the failure of a Dependent child to meet eligibility requirements, the Subscriber or Dependent must notify the Group, in writing, within 60 days of any of these events. The Group must notify the Dependents of their continuation of coverage rights within 14 days of receipt of notice from the Subscriber or Dependent.

2. The qualified Member must elect to continue the group health coverage within 60 days of the date that the coverage terminates or the date the notification of continuation of coverage rights is sent by the Group;

3. The qualified Member who elects continuation of coverage must not become covered under any other group health coverage plan;
4. The qualified Member must not become entitled to Medicare after electing continuation of coverage;
5. A totally disabled Member who is eligible to extend and who elects to extend his or her continuation of coverage after 18 months may not continue such coverage more than 30 days after a determination by the Social Security Administration that the Member is no longer disabled. The Member must inform the Group of the Social Security determination within 30 days of such determination;
6. The qualified Member electing continuation of coverage must meet all Premium payment requirements, and all other requirements, and all other eligibility requirements set forth in COBRA and to the extent not inconsistent with COBRA in this Certificate of Coverage; and
7. The Group must continue to provide group health coverage to its employees through FHCP.

An election by an employee or spouse shall be deemed to be an election for any other qualified beneficiary related to that employee or spouse, unless otherwise specified in the election form.

The Member does not need to show insurability to receive COBRA continuation of coverage. However, the Member must pay the applicable Premium charged by the Group.

In the case of a qualified Member whose maximum period of continuation of coverage expires, the Group must, during the 180-day period prior to such expiration date, provide the qualified Member the option of enrolling in a conversion health plan made available to the Members of the Group by FHCP. Additionally, FHCP shall allow such Member to apply for a conversion policy during the 63-day period immediately following the date such Member's maximum period of continuation of coverage expires.

Note: This Section shall not be interpreted to grant any Member any continuation rights in excess of those required by COBRA and/or Section 4980B of the *Internal Revenue Code*. Additionally, the Group Plan shall be deemed to have been modified, and shall be interpreted, to comply with COBRA and changes to COBRA that are mandatory with respect to the Group.

Section 9: Conversion Privilege

Under the State of *Florida Statutes*, if a Group is not subject to COBRA provisions, an individual previously covered under the Group Plan, whose Membership has terminated may apply for conversion to non-group membership.

This right to conversion also applies if the Group is subject to COBRA Provisions *(Employers with 20 or more employees)* and an individual's coverage under COBRA had terminated. **It is the sole responsibility of the Member to exercise this conversion privilege subject to the provisions set forth below**.

Eligibility Criteria for Conversion

A Member is entitled to apply for Non-group / Individual plan membership if:

1. The Member has been continuously covered under this Group Plan for three (3) months;
2. The Member was covered for at least three (3) months under any group policy providing similar benefits that this Group Plan immediately replaced;
3. The Member's coverage has been terminated for any reason, including discontinuance of this Group Plan in its entirety and termination of continued coverage under COBRA; and
4. The Member maintains his/her primary residence in the Service Area.

A Member's dependent(s) that was also covered under the Group Plan may also be covered under conversion to Non-group / Individual membership as dependents of the former covered employee.

In addition, once a Member's covered dependent(s) have been covered for 3 consecutive months or more under this Group Plan and before the coverage under this Group ends, the dependent(s) on their own may convert to a Non-group / Individual Plan under one of the following conditions:

1. If coverage would otherwise be lost by the death of a Subscriber under this Group's Plan or the Subscriber/Member's death while covered under COBRA;
2. The Spouse who would otherwise lose coverage because of an annulment or dissolution of marriage *(Divorce)*;
3. The Spouse of the Subscriber upon termination of the Spouse *(And the children whose coverage terminates at the same time),* while the Subscriber remains insured under this Group Plan, but no longer qualifying as an eligible dependent under this Group Plan; or
4. A child of the Subscriber / Member upon termination of his or her coverage due to no longer qualifying as an eligible dependent under this Group Plan.

The converted Non-group / Individual Plan shall be issued without regard to health status or requirements for Health Care Services.

Effective Date of Conversion; Reimbursement

The effective date of the converted Non-group / Individual Plan coverage shall be the day following the termination of Membership under the Group Plan or Cobra. However, until such time as coverage under the Individual Plan becomes effective, the Individual shall pay the Allowance for any Services or supplies rendered during the 63-day period immediately following such termination of Membership. In the event such Non-group / Individual Plan coverage becomes effective, an individual may request reimbursement from FHCP for any payment for Covered Services. The individual must submit proof of payment to FHCP in order to obtain reimbursement. **FHCP must receive the completed Non-group / Individual Plan application and the applicable Premium payment within the 63-day period beginning on the date this Group Plan terminated.** However, if coverage has been terminated due to the non-payment of Premium by the Group, FHCP must receive the completed Non-group / Individual Plan application and the applicable Premium payment within the 63-day period beginning on the date notice was given that this Group Plan terminated.

In the event FHCP does not receive the converted Non-group / Individual Plan application and the initial Premium payment within such 63-day period, the Member's application to convert to an Individual Plan will be denied and the Member will not be entitled to a converted group plan policy.

Conversion to a Non-group / Individual Plan is not available if termination occurred for any of the following reasons:

1. An individual had not been continuously covered under a group agreement for at least three (3) months prior to termination;
2. Failure to pay any required Premium unless such nonpayment was due to acts of an employer or person other than the individual;
3. Any Member contribution(s) required by FHCP are not paid by the Member when due;
4. Replacement of coverage by similar group coverage within 31 days of termination;
5. Fraud or intentional misrepresentation in applying for Membership or for any Covered Services;
6. Termination for cause as set forth in the *"Termination of Individual Membership for Cause"* sub-section;
7. The individual has left the Service Area with the intent to relocate or to establish a new residence outside the Service Area; or
8. The individual is eligible for, or covered under, Medicare or Title XVIII of the Social Security Act of 1965.

Additionally, conversion is not available:

a. If the individual is eligible for similar benefits, whether or not covered under any arrangement of coverage for individuals in a Group, whether on a Member or non-Member basis;

b. If the individual is covered by similar benefits by another hospital, surgical, medical, or major medical expense insurance policy, or hospital or medical service insured contract, or medical practice or other prepayment plan, or by any other plan or program;

c. If similar benefits are provided for or are available to the individual pursuant to or in accordance with the requirements of any state or federal law *(e.g., COBRA)*; or

d. If the benefits provided or available to the individual, together with the benefits provided by FHCP, would result in excess of coverage, as determined by FHCP's standards.

Converted Individual Plan Coverage

The converted Non-group Individual Plan issued to each former group plan enrollee who converts to Non-group / Individual membership shall include a level of benefits for "minimum services" which is similar to the level of benefits for the Services included in this Certificate of Coverage. For purposes of this Section, the term "minimum services" shall mean services which include any of the following: emergency care, inpatient hospital services, Physician care, ambulatory diagnostic treatment, and preventive health care services. Converted Non-group / Individual Plan coverage is not a continuation of the Group Plan. Benefits under such converted Non-group / Individual Plan coverage may differ from benefits under the Group Plan and any riders or Endorsements attached thereto.

Converted Non-group / Individual Plan coverage may continue in effect as long as each of the insured:

1. Continues to meet all applicable eligibility requirements;
2. Pays all applicable fees and charges; and
3. Otherwise complies with all requirements under the Non-group / Individual Plan.

Section 10: Duplication of Coverage

Coordination of Benefits

Coordination of Benefits is a limitation of coverage and/or benefits to be provided by FHCP. It is designed to avoid the costly duplication of payment for Health Care Services and/or supplies. FHCP shall coordinate payment of Covered Services to the maximum extent allowed by law provided Members follow the Coverage Access Rules set forth in the *"Coverage Access Rules"* Section. Contracts which may be subject to Coordination of Benefits include, but are not limited to, the following which will be referred to as "Plan(s)" for purposes of this Section:

1. Any group insurance, group-type self-insurance, or HMO Plan;
2. Any group contract issued by any Blue Cross and/or Blue Shield Plan(s);
3. Any plan, program, or insurance policy, including an automobile insurance or workers compensation policy provided that any such non-group policy contains a coordination of benefits provision; and
4. Medicare, as described in the "*Medicare Secondary Payer Provisions"* Section.

The amount of payment by FHCP, if any, is based on whether or not FHCP is the primary payer. When FHCP is primary, FHCP will provide Covered Services without regard to the Member's coverage under other plans. When FHCP is other than primary, Covered Services may be reduced so that, total benefits under all such plans will not exceed 100% of the total reasonable expenses actually incurred for Covered Services.

In the event, the Covered Services were rendered by a Contracted Provider, total reasonable expenses, for purposes of this Section, shall be equal to the amount FHCP is obligated to pay such Contracted Provider pursuant to the applicable provider contract.

The following rules shall be used to establish the order in which benefits under the respective Plans will be determined:

1. When FHCP covers the Member as a Dependent and the other plan covers the Member as other than a Dependent, FHCP will be secondary.
2. When FHCP covers a Dependent child whose parents are not separated or divorced:
    a. The Plan of the parent whose birthday, excluding year of birth, falls earlier in the year will be primary;
    b. If both parents have the same birthday, excluding year of birth, and the other plan has covered one of the parents longer than FHCP, FHCP will be secondary.
3. When FHCP covers a Dependent child whose parents are separated or divorced:
    a. If the parent with custody is not remarried, the plan of the parent with custody is primary;

b. If the parent with custody has remarried, the plan of the parent with custody is primary; the stepparent's plan is secondary; and the plan of the parent without custody pays last;

c. Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is primary.

4. When FHCP covers the Member as a Dependent child and the other plan covers the Member as a dependent child:

   a. The Plan of the parent who is neither laid off nor retired will be primary;

   b. 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.

5. When rules 1, 2, 3, and 4 above do not establish an order of benefits, the plan which has covered the Member the longest shall be primary.

6. FHCP 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.

Subrogation

If a Member is injured or becomes ill as a result of another party's intentional act or negligence, the Member must notify FHCP concerning the circumstances under which the Member was injured. Under Section §768.76, *Florida Statutes* the Member or the Member's lawyer must notify FHCP, by certified or registered mail, if the Member intends to claim damages from someone or a third party for injuries or illness. If the Member recovers money to compensate for the cost/expense of Health Care Services to treat the Member's illness or injury, FHCP is legally entitled to be reimbursed for payments made on the Member's behalf to the doctors, Hospitals, other providers, or for other medical and pharmacy services provided to or whom treated the Member. FHCP's legal right to be reimbursed in such cases is called "Subrogation." Normally, FHCP may recover the amount of any payments it made on the Member's behalf minus its pro rata share for any costs and attorney fees incurred by the Member in pursuing and recovering damages. FHCP may "Subrogate" against all money recovered regardless of the source of the money including but not limited to uninsured motorists coverage.

Right to Receive and Release Necessary Information

In order to administer coverage and/or benefits, FHCP may, without the consent of or notice to any person, plan, or organization, release to or obtain from any person, plan, or organization any information with respect to any Member or applicant for enrollment and other matters in which FHCP deems to be necessary.

Facility of Payment

Whenever payments which should have been made by FHCP are made by any other person, Plan, or Organization, FHCP shall have the right, exercisable alone and in its sole discretion, to pay over to any such person, plan, or organization making such other payments, any amounts FHCP shall determine to be required in order to satisfy its coverage obligations hereunder. Amounts so paid shall be deemed to be paid under the Group Plan and, to the extent of such payments, FHCP shall be fully discharged from liability.

Right of Recovery

Whenever FHCP has made payments in excess of the maximum provided, FHCP shall have the right to recover any such payments, to the extent of such excess, from any Member, person, plan, or other organization that received such payments.

Non-Duplication of Government Programs

The coverage and/or benefits provided by FHCP hereunder shall not duplicate any benefits to which Members are entitled, or for which they are eligible, under governmental programs such as Medicare, Veterans Administration, TRICARE, or any Workers' Compensation Act to the extent that such Member has been paid under any such programs. In the event, FHCP has duplicated such benefits, all sums paid or payable under such programs shall be paid or payable to FHCP to the extent of such duplication.

Cooperation Required of Members

Each Member shall cooperate with FHCP and shall execute and submit to FHCP such consents, releases, assignments, and other documents as may be requested by FHCP in order to administer and exercise its rights. Failure to do so shall constitute grounds for termination for cause by FHCP under the *"Termination of Individual Membership"* Section.

Section 11: Claims Review Processes: Pre-Service, Concurrent Care, & Post Service

Introduction

This Section is intended to:

- Help the Member understand what his or her treating providers must do, under the terms of this Certificate of Coverage, in order to obtain payment for expenses for Covered Services that have been rendered or will be rendered to the Member; and,
- Provide the Member with a general description of the applicable procedures FHCP will use for making Adverse Benefit Determinations, Concurrent Care Decisions, and for notifying the Member when FHCP denies benefits.

If the Group Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Employer / Plan Administrator is solely responsible for complying with ERISA. While the benefit determination timeliness standards set forth in this Section are generally consistent with ERISA, FHCP is not legally responsible for notifying the Member of any rights he or she may have under ERISA. If the Member is not sure of his or her rights under ERISA, the Member should contact the Employer / Plan Administrator or an attorney of his or her choice. FHCP will follow the claim determination procedures and notice requirements set forth in this Section even if the Group Plan is not subject to ERISA.

Under no circumstances will FHCP be held responsible for, nor will it accept liability relating to, the failure of the Group Plan's sponsor or Plan Administrator to:

1 Comply with ERISA's disclosure requirements;

2 Provide the Member with a Summary Plan Description *(PD)* as that term is defined by ERISA; or

3 Comply with any other legal requirements.

Types of Claims

For purposes of this Certificate of Coverage, there are three (3) types of claims:

1. **Pre-Service Claims** (*Also known as Prior-Authorization or Referral*) including concurrent and urgent care;
2. **Concurrent Care;** and
3. **Post-Service Claims**.

It is important that Members become familiar with the types of claims that can be submitted to FHCP and the timeframes and other requirements that apply.

THIS SECTION DESCRIBES THE THREE TYPES OF CLAIMS THAT MAY BE SUBMITTED TO FHCP.

1. Pre-Service Claims *(Also known as Prior-Authorization and/or Referral)*

How to file a Pre-Service Claim

This Certificate of Coverage may condition coverage, benefits, or payment *(in whole or in part)* for a specific Covered Service, upon the receipt by FHCP of a Pre-Service Claim *(Prior Authorization / Referral)* as that term is defined herein.

Some Services require Prior Authorization from FHCP for coverage **before** the Services are rendered. For these certain services, you, or the Provider are responsible for obtaining Prior Authorization from FHCP before such services are rendered.

In order to determine whether FHCP must receive a Pre-Service Claim for a particular Covered Service, please refer to the ***"Coverage Access Rules"*** Section, the "*Covered Medical Services*," "*Behavioral, Mental Health, & Substance Dependency Services*," and other applicable Sections of this Certificate of Coverage. The Member may also call the Member Service Department number on the Membership Card for assistance.

FHCP is not required to render an opinion or make coverage or benefit determinations with respect to a Service that has not actually been provided to the Member unless the terms of this Certificate of Coverage require Prior Authorization by FHCP *(or condition payment)* for the Service before it is rendered to the Member.

Benefit Determinations on Pre-Service *(Prior authorization / Referral)* Claims That Do Not Involve Urgent Care:

FHCP will use its best efforts to provide notice of a decision of a Pre-Service Claim not involving urgent care within 14 calendar days of receipt provided additional information is not required for a coverage decision. This 14 calendar-day determination period may be extended by FHCP one time for up to an additional 14 calendar days. If such an extension is necessary, FHCP will provide the Member with notice of the reasons for the extension and request the Member's permission to take an extension. FHCP will use its best efforts to provide notification of the decision on the Member's Pre-Service Claim within a total of 28 calendar days of the initial receipt of the claim, if an extension of time was taken by FHCP.

If additional information is necessary to make a determination, FHCP will use its best efforts to:

1. Provide written notice of the need for additional information, prior to the expiration of the initial 14 calendar day period;
2. Identify the specific information that the Member or the provider may need to provide;
3. Request the Member's permission for the extension;

4. Inform the Member of the date that FHCP reasonably expects to notify him or her of the decision; and
5. Inform the Member of his or her right to file a Fast *(24 hr.)* Grievance in the event the Member decides to revoke their permission for the extension.

If FHCP requests additional information, FHCP must receive it within 45 days of the request for the information. FHCP will use its best efforts to provide notice of the decision on the Pre-Service Claim within 14 days of receipt of the requested information.

A Pre-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards in this Section, and the appeal procedures described in the *"Complaint, Grievance, and Appeal Processes"* Section.

Benefit Determinations on Pre-Service (*Prior authorization / Referral*) Claims Involving Urgent Care: *(See "Glossary"* for definition of "*Emergency Medical Care*" and "*Urgent Care*.")

For a Pre-Service Claim Involving Urgent Care, FHCP will use its best efforts to provide notice of the determination (*Whether adverse or not*) as soon as possible, but not later than 24 hours after receipt of the Pre-Service Claim unless additional medical information is required for a coverage decision. If additional medical information is necessary to make a determination, FHCP will provide notice within 24 hours of:

1. The need for additional medical information;
2. The specific information that the Member or the provider may need to provide; and
3. The date that FHCP expects to provide notice of the decision.

If FHCP requests additional medical information, FHCP must receive it within 48 hours of the request.

FHCP must provide notice of the decision on the Pre-Service Claim for Urgent Care within 24 hours of receipt of the request. If additional medical information was requested, FHCP's total processing timeframe shall not exceed 72 hours from receipt of the request.

Medical Necessity

In order for Health Care Services to be covered under the Plan, such Services must meet all of the requirements to be a Covered Service, including being Medically Necessary, as defined by this Certificate of Coverage. (See the *"Glossary"* Section for a complete and detailed definition of *"Medical Necessity.")*

It is important to remember that any review of Medical Necessity by FHCP is solely for the purposes of determining coverage, benefits, or payment under the terms of the Group Plan and not for the purpose of recommending or providing medical care. In conducting a review of Medical Necessity, FHCP may review specific medical facts or information pertaining to you. Any such review is strictly for the purpose of determining whether a Health Care Service provided or proposed meets the definition of Medical Necessity. In

applying the definition of Medical Necessity to a specific Health Care Service, coverage and payment guidelines then in effect may be applied by FHCP.

All decisions that require, or pertain to, independent professional medical/clinical judgement or training, or the need for medical services, are solely your responsibility and that of your treating Physicians and health care Providers. You and your Physician(s) are responsible for deciding what medical care should be rendered or received and when that care should be provided.

Note: Whether or not a Health Care Service is specifically listed as excluded or otherwise not covered, 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 this Certificate of Coverage*) or a Covered Service. Please refer to the "*Glossary*" Section for the definition of "*Medical Necessity*."

Notifications of Pre-Service Determinations

Fully Favorable Determination

FHCP's Referral Department will notify you and /or your Provider verbally of any Fully Favorable Determination.

Manner and Content of a Notification of an Adverse Benefit Determination:

FHCP's Referral Department will notify you in writing of any Adverse Determinations. The written Notification of an Adverse Determination will:

1. List the specific reason or reasons for the Adverse Determination;
2. Refer to any specific Plan benefit from the "*Schedule of Benefits"* and/or *Covered Medical Services*," "*Behavioral, Mental Health, & Substance Dependency Services*," and other applicable Sections of this Certificate of Coverage that the Adverse Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Determination;
3. Describe any additional information that might change the determination and why that information is necessary;
4. Describe the Adverse Benefit Determination Appeal process and the time limits to request an appeal;
5. If the Adverse Determination is based on the "*Medical Necessity*' or "*Experimental or Investigational Exclusions and Limitations*," the notice will include any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Determination; and
6. A statement telling you and your Provider how to obtain at no charge, the specific explanation of the scientific or clinical judgment for the determination.

If the Prior Authorization is involving an urgent or expedited request of a service FHCP will notify you and your Provider verbally within the proper *(24 hour or 24 not to exceed 72-hour)* timeframes and will follow up with a written or electronic notification no later than three (*3*) business days after the verbal notification.

All documentation and materials utilized in making the "*Adverse Determination*" will be made available to you upon request and at no charge.

2. Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services:

A reduction or termination of coverage or benefits for services will be considered an Adverse Benefit Determination when:

1. FHCP has approved in writing coverage or benefits for an ongoing course of services to be provided over a period of time or a number of Services to be rendered;
2. The reduction or termination occurs before the end of such previously approved time or number of service(s); and
3. The reduction or termination of coverage or benefits by FHCP was NOT due to an amendment to the Certificate of Coverage or termination of the Member's coverage as provided by this Certificate of Coverage.

FHCP will use its best efforts to notify the Member of such reduction or termination in advance so that he or she will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the *"Complaint, Grievance, and Appeal Processes"* Section of this *Certificate of Coverage*. In no event, shall FHCP be required to provide more than a reasonable period of time within which the Member may develop his or her appeal before FHCP actually terminates or reduces coverage for the services.

Requests for Extension of Services:

The Member's provider may request an extension of coverage or benefits for a service beyond the approved period of time or number of approved Services. If the request for an extension is for a Claim Involving Urgent Care, FHCP will use its best efforts to notify the Member of the approval or denial of such requested extension within 24 hours after receipt of the request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such services. FHCP will use its best efforts to notify the Member within 24 hours if:

1. FHCP needs additional information; and
2. The Member or the Member's Authorized Representative failed to follow proper procedures in the request for an extension. (See "*Authorized Representative of the Member*" in the "*Glossary*" Section.)

If FHCP requests additional information, the Member will have 48 hours to provide the requested information. FHCP may notify the Member orally, unless the Member or the Member's representative specifically request that it be in writing. A denial of a request for an extension of services is considered an Adverse Benefit Determination and is subject to the *"Complaint, Grievance, and Appeal Processes"* Section of this *Certificate of Coverage*.

Notifications of Concurrent Care Determinations

Fully Favorable Determination

FHCP's Case Management Department will notify you and /or your Provider verbally of any Fully Favorable Determinations within the timeframes indicated above.

If the request was regarding an Inpatient admission, Continuation, Reduction, or Termination of Services you are currently receiving, and the determination is fully favorable the services will continue without interruption.

In the case of a termination of Service, the Service will resume. In all instances the Service will continue to be coordinated and reviewed by our Case Management Department.

Adverse Benefit Determination: Manner and Content of Notification

FHCP's Case Management Department will notify you in writing of any Adverse Determinations. The written Notification of an Adverse Determination will:

1. List the specific reason or reasons for the Adverse Determination;
2. Refer to any specific Plan benefit from the "*Schedule of Benefits*", the "*Covered Medical Services*", "*Behavioral, Mental Health, & Substance Dependency Services*", "*Exclusions & Limitations"* Sections, and other applicable Sections of this Certificate of Coverage that the Adverse Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Determination;
3. Describe any additional information that might change the determination and why that information is necessary;
4. Describe the Adverse Benefit Determination Appeal process and the time limits to request an appeal;
5. If the Adverse Determination is based on the "*Medical Necessity*" or "*Experimental or Investigational Exclusions and Limitations*," the notice will include any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Determination; and
6. A statement telling you and your Provider how to obtain at no charge, the specific explanation of the scientific or clinical judgment for the determination.

For requests involving Inpatient admission or continuation, reduction or termination of a service, or an expedited request as described above, FHCP will notify you and your Provider verbally within the proper *(24 hour or 24 not to exceed 72-hours)* timeframes and will follow up with a written or electronic notification no later than two (2) working days after the verbal notification.

All documentation and materials utilized in making the "*Adverse Determination*" will be made available to you upon request and at no charge.

3. Post Service Claims

How to File a Post-Service Claim

Experience shows that the most common type of claim FHCP will receive from the Member or his or her treating providers will likely be a Post-Service Claim.

Contracted Providers have agreed to file Post-Service Claims for Services rendered to the Member. If the Member receives a bill from a Contracted Provider, it should be forwarded to FHCP. If the Member requires Emergency Services and care from a Non-Contracted Provider while inside or outside the Service Area or, if FHCP refers the Member to a Non-Contracted Provider, then FHCP will pay for Covered Services provided to the Member. If the Member receives a bill from a Non-Contracted Provider for such Services, it should be forwarded to FHCP. FHCP relies on the information the Member provides when processing a claim.

FHCP must receive a Post-Service Claim within 180 days of the date the Health Care Service was rendered.

For Post-Service Claims, FHCP must receive a claim, either electronically or an approved form, containing the following information:

1. The date the Service was provided;
2. A description of the Service including any applicable procedure code(s);
3. The amount actually charged by the provider;
4. The diagnosis including any applicable diagnosis code(s);
5. The provider's name and address and National Provider Identification *(NPI)* number;
6. The name and date of birth of the individual who received the Service; and
7. The Member's name and Member number as they appear on the Membership Card.

Note: Also see "*Submission of Claims by a Member*" at the end of this Section.

The Processing of Post-Service Claims:

FHCP will use its best efforts to pay, contest, or deny all Post-Service Claims for which FHCP has all the necessary information, as determined by FHCP. Post-Service Claims will be paid, contested, or denied within the timeframes described below.

Payment for Post-Service Claims:

When payment is due under the terms of this Certificate of Coverage, FHCP will use its best efforts to pay *(in whole or in part)* for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, FHCP will use its best efforts to pay *(In whole or in part)* for paper Post-Service Claims within 30 days of receipt. The Member may receive notice of payment for claims within 30 days of adjudication. If FHCP is unable to determine whether the claim or a portion of the claim is payable because FHCP needs more or additional information, FHCP may contest or deny the claim within the timeframes set forth below.

Contested Post-Service Claims:

In the event FHCP contests a submitted Post-Service Claim, or a portion of such a claim, FHCP will use its best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event FHCP contests a paper Post-Service Claim, or a portion of such a claim, FHCP will use its best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. The notice may identify:

1. The contested portion or portions of the claim; and
2. The reason(s) for contesting the claim or a portion of the claim.
3. The notice may also indicate whether more information is needed in order to complete processing of the claim. If FHCP requests additional information, FHCP must receive it within 45 days of the request for the information. **If FHCP does not receive the requested information, the claim, or a portion of the claim will be adjudicated based on the information in FHCP's possession at the time and may be denied.** Upon receipt of the requested information, FHCP will use its best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

Denial of Post-Service Claims:

In the event FHCP denies a Post-Service Claim, FHCP will use its best efforts to provide notice, within 20 days of receipt of the claim, that the claim or a portion of the claim is denied. In the event FHCP denies a paper Post-Service Claim, FHCP will use its best efforts to provide notice, within 30 days of receipt of the claim, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the claim and the reason(s) for denial. It is the Member's responsibility to ensure that FHCP receives all information that FHCP determines is necessary to adjudicate a Post-Service Claim. **If**

FHCP does not receive the necessary information, the claim or a portion of the claim may be denied.

A Post-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards in this Section and the appeal procedures described in the *"Complaint, Grievance, and Appeal Processes"* Section.

Additional Processing Information for Post Service Claims:

In any event, FHCP will use its best efforts to pay or deny all *(1)* electronic Post-Service Claims within 90 days of receipt of the completed claim; and *(2)* paper Post-Service Claims within 120 days of receipt of the completed claim. Claims processing shall be deemed to have been completed as of the date the notice of the decision is deposited in the mail by FHCP or otherwise electronically transmitted. Any claims payment relating to a Post-Service Claim that is not made by FHCP within the applicable timeframe is subject to the payment of simple interest at the rate established by the Florida Insurance Code.

Standards for Adverse Post-Service Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination:

FHCP will use its best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include *(or will be made available to the Member free of charge upon request)*:

1. The specific reason or reasons for the Adverse Benefit Determination;
2. A reference to the specific Certificate of Coverage provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
3. A description of any additional information that might change the determination and why that information is necessary;
4. A description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
5. If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational Limitations and Exclusions, a statement telling the Member how to obtain the specific explanation of the scientific or clinical judgment for the determination which will be made available to the Member free of charge upon request.

Additional Claims Processing Provisions

Release of Information/Cooperation:

In order to process claims, FHCP may need certain information, including information regarding other health care coverage the Member may have. The Member must cooperate with FHCP in its effort to obtain such information by, among other ways, completing a "*Coordination of Benefits"* form, signing any release of information form at FHCP's request. Failure by the Member to fully cooperate with FHCP may result in a denial of the pending claim and FHCP will have no liability for such claim.

Legal Actions:

No legal action arising out of or in connection with coverage under this Certificate of Coverage may be brought against FHCP within the 60-day period following FHCP's receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statute of limitations.

Fraud, Misrepresentation or Omission in Applying for Benefits:

FHCP relies on the information provided on the itemized claim form when processing a claim. Therefore, all such information must be accurate, truthful, and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result, in addition to and not limiting any other legal remedy FHCP may have, in denial of the claim or cancellation or rescission of the Member's coverage.

Communication of Claims Decisions:

All claims decisions, including denial and claims review decisions, will be communicated to the Member in writing. This written correspondence may indicate:

1. The specific reason or reasons for the Adverse Benefit Determination;
2. Reference to the specific Certificate of Coverage provisions upon which the Adverse Benefit Determination is based as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
3. A description of any additional information that would change the initial determination and why that information is necessary;
4. A description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
5. If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling the Member how they can obtain the specific explanation of the scientific or clinical judgment for the determination free of charge.

Circumstances Beyond the Control of FHCP

To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within the control of FHCP, results in facilities, personnel, or financial resources of FHCP being unable to process claims for Covered Services, FHCP will have no liability or obligation for any delay in the payment of claims for Covered Services, except that FHCP will make a good faith effort to make payment for such Services, taking into account the impact of the event. For the purposes of this paragraph, an event is not within the control of FHCP if FHCP cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

Submission of Post Service Claims by a Member

There may come a time that you have been billed for services you believe should have been covered by FHCP. There may be certain circumstances you may have been required to pay for services at the time the services are rendered such as; emergency services, services received from non-contracted, out-of-network providers, or deductible, copayment, or coinsurance amounts that you believe should not apply. Any time you receive a bill or request reimbursement for a payment you have already made you must submit these claims to FHCP's Claims Department within 180 days after the date service(s) was rendered. If it is not reasonably possible to submit a claim in the time required, FHCP will not reduce or deny the claim for this reason if proof is filed as soon as possible. In any event any claim for payment or reimbursement submitted by a Member must be submitted no later than 1 year after the date of occurrence unless the Member was legally incapacitated.

When a Member submits any claim either for payment or reimbursement the claim must include ALL the following information:

1. The date of service;
2. The place of service;
3. The Member's name, date of birth, and the Member number as they appear on the Membership Card of the person who received the service
4. The Name of the Provider and whenever possible/applicable the National Provider Identification (NPI) number;
5. The type of service(s) rendered. This information should also include the corresponding CPT code whenever possible;
6. The reason for the visit and/or service. This is commonly referred to as the diagnosis and can include a corresponding ICD-10 code;
7. Include the medical records and/or other supporting documentation. Whenever services are rendered outside of the United States any records in a foreign language must be translated into English; and
8. Any requests for reimbursement must include a copy of the paid receipt(s).

All Member requests for claims payment or reimbursement must be submitted to FHCP's Claims Department. The address and phone number are listed in the "*Telephone Numbers and Addresses"* sub-section.

Section 12: Coverage Access Rules

It is important that Members become familiar with the rules for accessing health care coverage through FHCP. The following sections explain the role of FHCP and the Primary Care Physician (PCP), how to access specialty care coverage through FHCP and the Primary Care Physician, and what to do if Emergency Services and Care is needed. It is also important for the Member to review all Service Area-specific Coverage Access Rules for particular types of services and Contracted Providers within the Service Area. These Service Area-Specific Coverage Access Rules, if any, are set forth in the provider directory and may vary based on negotiated provider contracts and other network factors specific to the Service Area.

Choosing a Primary Care Physician

The first and most important decision each Member must make when joining a health maintenance organization is the selection of a Primary Care Physician. This decision is important since it is through this Physician that all other health services, particularly those of Specialists, are coordinated.

The Member is free to choose any Primary Care Physician who participates in the Provider Network associated with the Member's FHCP benefit plan and whose practice is open to additional Members. This choice should be made when the Member enrolls. The Subscriber is responsible for choosing a Primary Care Physician for all minor Dependents, including a newborn child or an adopted newborn child. If the Member fails to choose a Primary Care Physician when enrolling, FHCP will assign one to the Member and notify the Member of that assignment. Members can change their assigned PCP at any time. A female Member may select as her primary care physician a contracted obstetrician/gynecologist who has agreed to service as a Primary Care Physician in FHCP's provider network.

The following includes important information concerning the Member's Primary Care Physician relationship:

Primary Care Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate the Member's overall health care needs. Developing and continuing a relationship with a Primary Care Physician allows the Physician to become knowledgeable about the Member's health history. A Primary Care Physician can help the Member determine the need to visit a Specialist and help the Member find one based on their knowledge of FHCP's Networks, the Member and their specific healthcare needs. A Primary Care Physician may specialize in internal medicine, family practice, general practice, or pediatrics. Additionally, care rendered by the Member's Primary Care Physician usually results in lower out of pocket expenses for the Member. Refer to the Primary Care Physicians Section(s) of the Provider Directory for Physicians who are Primary Care Physicians. The Primary Care Physician selected by the Member

maintains a Physician-Patient relationship with the Member and will be responsible for helping to coordinate medical Services for the Member.

IMPORTANT: You should also ask whether the Primary Care Physician has a referral relationship with any specialist you are currently seeing or may wish to see. Your choice of Primary Care Physician may affect your access to certain Network specialists.

FHCP wants the Member and the Primary Care Physician to have a good relationship. To be certain this relationship is conducive to effective health care, both the Member and the Primary Care Physician may request a change in the Primary Care Physician assignment:

1. The Member may request a transfer to another Primary Care Physician whose practice is open to enrollment of additional Members. The transfer of care to the newly selected Primary Care Physician shall be effective immediately upon FHCP's receipt and entry of the Members request.
2. Instances may occur where the Primary Care Physician, for good cause, finds it impossible to establish an appropriate and viable physician-patient relationship with the Member. In such a circumstance, the Primary Care Physician may request that FHCP assist the Member in the selection of another Primary Care Physician.

If the Primary Care Physician selected by the Member terminates his or her contract with FHCP or is unable to perform his or her duties or is on a leave of absence, FHCP may assist the Member in selecting, or FHCP may assign, another Primary Care Physician to the Member.

Members may request assistance in their selection of a Primary Care Physician by contacting the Member Services Department at the telephone number listed in the "*Telephone and Addresses"* sub-section.

Note: If you have a Point-of-Service or Triple Option Plan you will not be required to select a Primary Care Physician from our Provider Directory. You have the right to select any Primary Care Physician of your choosing regardless of the physician's status with FHCP *(Contracted or Non-Contracted).* In addition, in the event the Member in a Point of Service or Triple Option Plan does not to choose a PCP, FHCP will automatically assign one.

Specialist Care

If a Member requires an office visit to a Specialist, in most cases the Member and/or the Member's Primary Care Physician may choose a Contracted Specialist from the Specialists participating in the Member's Provider Network.

The Member's Primary Care Physician may consult with FHCP regarding coverage or benefits and with the Specialist in order to coordinate the Member's care. This procedure provides the Member with continuity of treatment by the Physician who is most familiar with the Member's medical history and who understands the Member's total health profile.

Members must obtain referrals from their Primary Care Physician to see a Contracted Specialist unless the Specialist is designated as a *"Direct Access Provider"* in the FHCP

Provider Directory. Also, some services require Prior Authorization for coverage. For these certain services, the FHCP Contracted Provider is responsible for obtaining coverage authorization from FHCP.

When going to a Specialist's office the Member is responsible for the applicable Specialist copayment, coinsurance or deductible even if the Member was seen by an Advanced Registered Nurse Practitioner (ARNP), Physician Assistant (PA) or master's level Certified Licensed Professional acting under the guidance of the Specialist.

Types of Services that Require Prior Authorization

The following are the most commonly requested, non-emergency services that require Prior Authorization.

NOTE: The following listing is subject to change.

1. Cardiac Catheterization;
2. Cardiac Rehabilitation;
3. Certain Diagnostic Studies and Procedures:
    a. Breast MRI's;
    b. CT Colonography (*aka Virtual Colonoscopy)*;
    c. Certain Genetic Testing;
    d. PET Scans;
    e. Pill Cams;
    f. Sestamibi Scans; and
    g. Stereotactic Breast Biopsies.
4. Certain Injections and Infusion Therapy;
5. Certain Provider Administered Drugs;
6. Certain Durable Medical Equipment *(including but not limited to*):
    a. Alternating Pressure Relieving Mattresses;
    b. Bone Growth Stimulators;
    c. Mattress Gel Overlays;
    d. Mattress Replacement Systems;
    e. Pumps and Pads;
    f. Wheelchair Cushions; and
    g. Wound Vacs.
7. Clinical Trials;

8. Hyperbaric Oxygen Therapy;
9. Litholink Services;
10. Lymphedema Therapy;
11. Medical Braces / Prosthetics. *(*See the *"Covered Medical Services"* and the *"Exclusions and Limitations"* Sections);
12. Medical Hematology / Oncology Therapy;
13. Oral Surgery (See the "*Covered Medical Services"* and "*Exclusion and Limitations"* Sections);
14. Physical Medicine and Rehabilitation Services;
15. Plastic Surgeon (See the *"Covered Services"* and "*Exclusions and Limitations"* Sections);
16. Certain Medications that require prior authorization (See your *"Medical Pharmacy Formulary"* and *"Prescription Drug Formulary")*;
17. Pulmonary Rehabilitation;
18. Radiation Oncology Therapy;
19. Second & Third Medical Opinions;
20. Second & Third Surgical Opinions;
21. Services provided by a Mid-wife in the Home;
22. Services provided at Non-Contracted Hospitals;
23. Services provided by Non-Contracted Providers;
24. Services provided for, and related to, Organ and Bone Marrow Transplants;
25. Skilled Nursing / Rehabilitation Facilities Admissions;
26. Surgeries: All surgeries, elective and non-elective *(including Emergency Surgery whenever possible)*, inpatient or outpatient;
27. Tertiary Care Services, Admissions, Procedures, Testing or Surgery, inpatient or outpatient; and
28. Varicose Vein Treatment.

If non-emergency services from a Non-Contracted Provider are required or received, payment for such services will only be made if Prior Authorization was obtained from FHCP.

If you have a Point of Service (POS) or Triple Option Plan you have direct access to certain specialists without a referral from your PCP. However, Prior Authorization is still required for the above listed services. See your "*Summary of Benefits and Coverage*" and "*Schedule of Benefits*" for details.

The Member's Primary Care Physician or Contracted Specialist who is treating the Member is responsible for obtaining prior authorization.

Note: Prior authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition.

Pre-Certification

If you are being admitted to a hospital as an inpatient or for emergency or 23-hour observation services your provider or, in the case of an out of area emergency, you must notify FHCP's Case Management Department at the address and telephone number listed in the "*Telephone Numbers and Addresses"* sub-section. The purpose of this notification is for data entry and post-service claims processing only. Pre-Certification will determine the level of copayment, coinsurance, and/or deductible you will be financially responsible for.

Note: If you have a Point-of-Service (POS) or Triple Option Plan, in addition to Hospital Services, other services may also be subject to Pre-Certification, please see your "*Summary of Benefits and Coverage"* and *"Schedule of Benefits"* for complete information.

Emergency and Urgent Services and Care Covered Worldwide

IN THE EVENT OF AN EMERGENCY, GO TO THE NEAREST HOSPITAL OR CLOSEST EMERGENCY ROOM OR CALL 911.

Emergency Services and Care in or out of the Service Area are Covered Services and do not require prior notification to, or Prior Authorization by, FHCP. Coverage is subject to the Copayment, Coinsurance, and/or Deductible amount set forth in the "*Summary of Benefits and Coverage"* and *"Schedule of Benefits."* It is the Member's responsibility, however, to notify FHCP as soon as possible, when the Member receives Emergency Services and Care and/or any admission which results from an Emergency Medical Condition. If a determination is made that an Emergency Medical Condition does not exist, payment for services rendered subsequent to that determination will be the responsibility of the Member.

The Member must contact his/her Primary Care Physician and FHCP within 48 hours after the Emergency service is rendered.

Follow-up care must be rendered by a Primary Care Physician or a Contracted Specialist. If the follow-up care is provided by other than a Primary Care Physician or Contracted Specialist, coverage may be denied.

Non-emergency care received outside of FHCP's Service Area is not covered unless you have a Point of Service *(POS)* or Triple Option Plan or you have received Prior Authorization from FHCP.

Note: When Emergency Care is received outside of our Service Area and follow-up care is needed, the Member must notify FHCP and the Primary Care Physician as soon as possible to have his or her follow-up care coordinated by the Member's Primary Care

Physician and to obtain Prior Authorization from FHCP. **Payment for any follow up services received that have not been Pre-Authorized by FHCP will be the responsibility of the Member.**

Payment for Emergency Services and Care rendered by Non-Contracted Providers will be the lesser of the provider's charges, the usual and customary provider charges for similar services in the community where the services were provided, or the charge mutually agreed to by FHCP and the provider within 30 days of the submittal of the claim for such Emergency services and Care. It is the responsibility of the Member to furnish to FHCP written proof of loss in accordance with the "*Claims Review"* Section.

Urgent Care Services are services rendered within FHCP's Service Area in an Urgent Care Facility or other "After Hours Center" by Physicians, RNs, and other medical professional staff licensed in the State of Florida. Outside the Service Area urgently needed service may be rendered by any medical professional licensed in the state where the services are being rendered. The medical professional rendering the service must have appropriate training and skills for the care of adults and children. If a determination is made that the service(s) rendered does not meet urgent criteria and/or the services were rendered within FHCP's Service Area during the hours the Member's Primary Care Physician's office was open and available, payment for services rendered will be the responsibility of the Member.

Whenever you wish to seek urgent, but not emergent care electronically, FHCP has contracted with a Telemedicine / Telehealth group of providers. With this service, you will be able to connect to a Board-Certified Physician or Mental Health/Behavioral Health Specialist via teleconferencing from anywhere in the United States. The contact information and download for the Telemedicine / Telehealth app is available on FHCP's website at https://www.fhcp.com/ **(**See the *"Limitations"* sub-section of the *"Exclusions and Limitations"* Section*).*

Verifying Provider Participation

The Member is responsible for verifying the participation status of the Physician, Hospital, or other provider prior to receiving the Health Care Service. To determine if a particular health care provider is in the FHCP Provider Network:

1. The Member can access the specific Provider Network associated with the benefit plan via the FHCP Member Portal. Access to the Portal is available to all Members and can be activated by visiting FHCP's Website https://www.fhcp.com/ and selecting the Member Portal link;

2. Members can access the most recent Provider Directory listing those Primary Care Physicians and Contracted Providers under the Group Plan on-line at https://www.fhcp.com/; or

3. Verify a specific health care provider's participation status by contacting the FHCP's Member Services Department at the telephone number listed in the "*Telephone Numbers and Addresses"* sub-section.

Failure to verify participation status or to show the Membership Card may result in noncompliance with required FHCP procedures and coverage may be denied.

Case Management

FHCP reserves the right *(But, in no event shall it be required)* to offer its Case Management Program to its Members. FHCP may use its Case Management Program policies and procedures then in effect. FHCP's use of Case Management Program policies and/or procedures with respect to any Member shall not restrict or otherwise modify FHCP's right to administer coverage and/or benefits in strict accordance with the terms of this Certificate of Coverage with respect to said Member or with respect to any other Member or other individual under any other policy or contract. Further, when the cost of providing alternative or equivalent services varies, depending upon whether or not a particular provider or supplier is contracted to provide such service, FHCP may *(but shall not be required to)* take such variations into consideration when authorizing or approving payment, coverage, or benefits for such services under the Case Management Program. Members may directly contact our Case Management Department at the address and telephone number listed in the "*Telephone Numbers and Addresses"* sub-section.

Examples of Members who might be eligible for one of the Case Management Department's Programs would be Members:

1. With multiple co-morbidities (*multiple conditions for which you receive ongoing treatment*);
2. Who require complex care;
3. Who have multiple hospitalizations; or
4. Who have utilized emergency room services multiple times.

Other Care Initiatives

FHCP, at its sole discretion, may make available alternative care initiatives for cost effective health care services. Members may decline to participate. Other care initiatives may be made available by FHCP on a **case-by-case** basis. The fact that FHCP has offered to provide payment for these services or has provided and paid for these services previously, in no way obligates FHCP to continue to provide or pay for same or similar services. Such programs available to Members are subject to Medical Necessity review, prior approval by FHCP, and other criteria deemed relevant by FHCP.

Nothing contained in this Section shall be deemed a waiver of our right to enforce the Group Contract in strict accordance with its terms. The terms of the Group Contract will continue to apply, except as specifically modified in writing by us upon renewal.

Note: Certain services, including those offered above as part of the Case Management and Other Initiatives, once approved, will be subject to the Member's applicable copay, deductible, and/or coinsurance for the type of service(s) rendered. Please see your *"Summary of Benefits and Coverage"* and *"Schedule of Benefits"* for complete information.

Note: Members with Point of Service (POS) and Triple Option Plans. Services offered through the programs mentioned above must be rendered by an HMO network provider that is contracted with FHCP to provide these services. Utilization of any Out-Of-Network, Non-Contracted Provider(s) will NOT be covered under your POS or Triple Option Plan.

Access to Osteopathic Hospitals

At the option of the Member, inpatient and outpatient services, similar to inpatient and outpatient services by allopathic Hospitals, may be obtained from a Hospital accredited by the American Osteopathic Association when such services are available in the Service Area and when such Hospital has not entered into a written agreement with FHCP with regard to such services. The Hospital providing such services may not charge rates that exceed the Hospital's usual and customary rates less the average discount that FHCP has with allopathic Hospitals within the Service Area. It is the Member's responsibility to contact FHCP to obtain the documents necessary to comply with this provision.

Access to Other Contracted Providers

Other Primary Care Physicians:

Members may access Primary Care Physicians, other than the Primary Care Physician they have selected, for urgently needed services or when the Physician is "Covering" for the Member's Primary Care Physician. The copayment, coinsurance, or deductible applicable to Urgent Care Services listed on the *"Summary of Benefits and Coverage*" and *"Schedule of Benefits"* will apply to these Services.

Contracted Specialists:

Members may access Contracted Specialists for office visits, except for preventive health services described in the "*Covered Medical Services"* Section, upon referral from their Primary Care Physician. Certain services may require FHCP Prior Authorization which must be obtained by the requesting Physician prior to rendering the service to the Member. Please refer to the "*Pre-Service / Prior Authorization"* sub-section for additional information.

Note: Members with Point of Service (POS) or Triple Option Plans may access any Contracted Specialist without Prior Authorization from their Primary Care Physician or prior authorization of coverage from FHCP. (See your *"Summary of Benefits and Coverage"* and *"Schedule of Benefits"* for complete information.)

Direct Access Providers:

Members have access to services rendered by designated "Direct Access Providers" as noted in the Provider Directory without Prior Authorization. These types of Direct Access Providers are as follows:

Chiropractors:

Members have access to services rendered by Chiropractors who are Contracted providers without Prior Authorization from their Primary Care Physician or FHCP. (See "*Chiropractic Treatment*" in the "*Covered Medical Services"* Section.)

Dermatologists:

Members have access to Dermatologists who are Contracted Providers for a maximum of five (5) visits within a Calendar Year. Any services rendered above these five (5) visits require Prior Authorization from FHCP. If you do not get an authorization from the Plan, any visits in excess of five (5) within a Calendar Year will not be covered. (See the *"Covered Medical Services"* Section.)

Obstetricians and Gynecologists:

Female Members have access to Contracted Gynecologists and Obstetricians without Prior Authorization from their Primary Care Physician or FHCP. (See the *"Covered Medical Services"* Section.)

Optometrists:

Members have access to contracted Optometrists for covered medical services and screenings without Prior Authorization from their Primary Care Physician or FHCP. (See the *"Covered Medical Services"* Section.)

Note: Members must have a Vision Rider through their Group Plan in order to have coverage for routine refractions for the purpose of eyeglasses or contact lenses.

Podiatrists:

Members have access to Podiatrists who are Contracted Providers for certain services. (See the *"Covered Medical Services"* Section.)

IN ADDITION TO THE DIRECT ACCESS PROVIDERS LISTED IN THE PROVIDER DIRECTORY, MEMBERS ALSO HAVE ACCESS TO THE FOLLOWING DURING CERTAIN TYPES OF MEDICAL PROCEDURES AND SERVICES LISTED BELOW.

Physician Assistant:

Members have access to surgical assistant Services rendered by a Physician Assistant only when acting as a surgical assistant. Certain types of medical procedures and other Services covered hereunder may be rendered by licensed Physician Assistants, Nurse Practitioners, or other individuals who are not Physicians.

Certified Registered Nurse Anesthetist:

Members have access to anesthesia services within the scope of a duly licensed Certified Registered Nurse Anesthetist's license if the Member requests such services provided such services are available, as determined by FHCP, and are Covered Services under the Group Plan.

Services Not Available from Contracted Providers

Except as provided in the Covered Services Sections, if a Covered Service is unavailable through Contracted Providers, FHCP will authorize coverage for such services to be rendered by a Non-Contracted Provider.

Note: Covered Services provided by a Non-Contracted Provider under this provision must be Prior Authorized by FHCP.

Contracted Provider Financial Incentive Disclosure

Health care decisions are the shared responsibility of Members, their families, and health care providers. A health care provider's decision regarding medical care may have a financial impact on the Member and/or the provider. For example, a provider in his/her provider contract with FHCP may agree to accept financial responsibility for medical expenses of Members. **Consequently, FHCP encourages Members to discuss with their providers how, and to what extent, the acceptance of financial risk by the provider may affect the provider's medical care decisions.**

Continuity of Coverage and Care upon Termination of a Provider Contract

When a provider contract between FHCP and any Contracted Provider *(including a PCP)* is terminated by FHCP or the provider without cause, a Member who, at the time of the Contracted Provider's termination, is actively receiving treatment for a Condition shall continue to be covered *(for treatment of that Condition)* after the date of the Contracted Provider's termination. Coverage for that Condition shall continue only until:

1. The completion of treatment for the Condition;
2. The Member selects another Contracted Provider; or
3. The next Open Enrollment Period.

FHCP shall not be required to provide coverage under this provision for longer than six months after termination of the provider's contract with FHCP. If a shorter period of coverage is permitted under applicable Florida law, FHCP shall not be required to provide coverage for longer than such shorter period.

FHCP will continue to provide maternity benefits under this Group Plan, regardless of the trimester in which care was initiated, until completion of postpartum care for a pregnant Member who has initiated a course of prenatal care prior to the termination of the Contracted Provider's contract.

Note: FHCP is not required to cover or pay for any services under this sub-section for an individual whose coverage under this Group Plan is not in effect at the time that Services are rendered. Further, this sub-section does not apply if the Contracted Provider is terminated "for cause."

Statewide, National, and Worldwide Network Programs Introduction

The "BlueCard® & Blue Cross Blue Shield Global® Core Program" is an out-of-area program sponsored by the Blue Cross Blue Shield Association (BCBSA) that is available to Members of FHCP when the eligibility requirements of the Member are in effect. BlueCard® & Blue Cross Blue Shield Global® Core Program access is defined as a courtesy membership for FHCP Members who are **temporarily** outside of our HMO Service Area. **Florida Health Care Plan, Inc. is your Home HMO**.

Under this program, FHCP's Members will have access to an expanded network of providers in the event a Member requires Urgently Needed Care while traveling outside of our Service Areas *(See attachment A of this Certificate of Coverage)*, this expanded network will depend on the Member's location at the time the services are needed.

The Blue Cross Blue Shield Global® Core Program is a program that is also sponsored by the Blue Cross Blue Shield Association *(BCBSA)* that is made available to all eligible Members of FHCP and provides coverage for Emergency and Urgent Services and Care when Members are traveling outside of the United States.

Note: Complete information on both the BlueCard® & Blue Cross Blue Shield Global® Core Program can be found in the "*BlueCard® & Blue Cross Blue Shield Global® Core Program"* Section in this Certificate of Coverage.

Important Reminders:

HMO Members must utilize contracted FHCP providers unless you have obtained Prior Authorization from FHCP. **You are only covered for Emergency and Urgently needed care when outside of our Service Area. Routine service received outside of our Service Area without Prior Authorization will not be covered and you will be responsible for the entire charge.**

Note: If you have a Point-of-Service (POS) or Triple Option Plan, you may utilize any provider in the BCBSF HMO network when outside of our Service Area *(Florida Counties of Brevard, Flagler, Seminole, St. Johns, and Volusia*) but within the State of Florida or any provider within the BCBS BlueCard provider network when you are outside of the State of Florida but within the United States. If you received Emergency or urgently needed care and you have the Point-of-Service or Triple Option Plan the care you receive will be covered at the HMO benefit level. **If you received routine care, any Pre-Certification, Prior Authorization, or other benefit requirement will apply. For routine care received without Pre-Certification or Prior Authorization, your POS or Triple Option level of benefit will be automatically applied.**

Section 13: Relationships Between the Parties

Members and Contracted Providers

The relationship between Members and Contracted Providers shall be that of a health care provider-patient relationship, in accordance with any applicable professional and ethical standards.

FHCP and the Group

Neither the Group nor any Member is the agent or representative of FHCP and neither shall be liable for any acts or omissions of FHCP, its agents, servants, or employees. Additionally, neither the Group, any Member; or FHCP shall be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which FHCP has made or hereafter makes arrangements for the provision of Covered Services. FHCP is not the agent, servant, or representative of the Group or any Member, and shall not be liable for any acts or omissions of the Group, its agents, servants, employees, any Member, or any person or organization with which the Group has entered into any agreement or arrangement. By acceptance of Covered Services hereunder, each Member agrees to the foregoing.

Medical Decisions are the Responsibility of Member's Physician, Not FHCP

All decisions that require or pertain to independent professional medical judgment or training, or the need for medical services or supplies, must be made solely by the Member, the Member's family and the Member's treating Physician in accordance with the Patient-Physician relationship. It is possible that the Member or the Member's treating Physician may conclude that a particular procedure is needed, appropriate, or desirable, even though such procedure may not be covered.

Note: Non-covered services are the financial obligation of the Member. Be sure to review the *"Coverage Access Rules,"* "*Covered Medical Services*," "*Behavioral, Mental Health & Substance Dependency Services*," and *"Exclusions and Limitations"* Sections.

Section 14: General Provisions

Access to Information

FHCP shall have the right to receive from any health care provider rendering services to a Member, information that is reasonably necessary, as determined by FHCP, in order to administer the coverage and/or benefits it provides, subject to all applicable confidentiality requirements set forth below. By accepting Membership, each Member authorizes every health care provider who renders services or furnishes supplies to such Member, to disclose to FHCP or to entities affiliated with FHCP, upon request, all facts, records, and reports pertaining to such Member's care, treatment, and physical or mental condition, and to permit FHCP to copy any such records and reports so obtained.

Amendment

The terms of coverage and/or benefits to be provided by FHCP under the Group Plan may be amended at any time by FHCP, without the consent of the Group, any Member, or any other person upon 30 days prior written notice to the Group. In the event the amendment is unacceptable to the Group, the Group may terminate the Group Plan upon at least ten (10) days prior written notice to FHCP. Any such amendment shall be without prejudice to claims filed with FHCP prior to the date of such amendment. No agent or other person, except a duly authorized officer of FHCP, has the authority to modify the terms of this Certificate of Coverage, or to bind FHCP in any manner not expressly set forth herein, including but not limited to the making of any promise or representation, or by giving or receiving any information. The terms of coverage and/or benefits to be provided by FHCP under the Group Plan may not be amended by the Group unless such amendment is evidenced in writing and signed by a duly authorized representative of the Group and a duly authorized officer of FHCP. The Group shall immediately notify each Subscriber of any such amendment and shall assist FHCP in so notifying the Subscribers if requested by FHCP.

Assignment and Delegation of Policy and/or Benefits to a Non-Provider Third Party

The obligations arising hereunder may not be assigned, delegated, or otherwise transferred by either party without the written consent of the other party; provided, however, that FHCP may assign its coverage and/or benefit obligations to its successor in interest or an affiliated entity without the consent of the Group at any time. **Any assignment, delegation, or transfer made in violation of this provision shall be void.**

Assignment of Benefits to Providers

Except as set forth in the last paragraph of this Section, FHCP will not honor any of the following assignments or attempted assignments, by a Member to any provider, including, without limitation, any of the following:

1. An assignment of the benefits due the Member under this Certificate of Coverage;
2. An assignment of the right to receive payments due under this Certificate of Coverage; or
3. An assignment of a claim for damage resulting from a breach, or an alleged breach, of any promise or obligation set forth in this Certificate of Coverage, or any promise or obligation set forth in any contract, plan, or policy.

FHCP specifically reserves the right to honor an assignment of benefits or payment by a Member to a provider who:

1. Is a Contracted Provider under the Member's plan of coverage or a Provider, if not expressly contracted, has been Pre-Authorized by FHCP to render a specific service(s);

2. Is a licensed Hospital, Physician, or dentist and the benefits which have been assigned for care provided pursuant to Section §395.1041, *Florida Statutes*; or

3. Is an Ambulance provider that provides transportation for Services from the location where an Emergency Medical Condition, defined in Section §395.002(8), *Florida Statutes*, first occurred to a Hospital, and the benefits which have been assigned are for transportation to care provided pursuant to Section §395.1041, *Florida Statutes*. A written attestation of the assignment of benefits may be required.

Attorney Fees: Enforcement Costs

Unless otherwise agreed to in writing, if any legal action or other proceeding is brought under the Group Plan to enforce the terms of coverage and/or benefits provided, or to be provided, by FHCP, or because of an alleged dispute concerning, or breach of such terms, the successful or prevailing party or parties shall be entitled to recover reasonable attorney's fees, court costs, and other reasonable expenses incurred in connection with maintaining or defending such action or proceeding. Such entitlement to recover shall include attorney's fees, costs, or expenses incurred in connection with any appeal. These recoveries are in addition to any other relief to which such party or parties may be entitled.

Changes in Premium

FHCP may modify the Premium, without the consent of the Subscriber or any Member, upon at least 30 days prior notice to the Group in accordance with applicable law.

Complaint, Grievance, and Appeal

FHCP has established and will maintain a process for hearing and resolving Complaints, Grievances, and Appeals raised by Members. Members are required to first bring Complaints, Grievances, and Appeals to the attention of FHCP's Member Services Department, at the telephone number and address listed in the *"Telephone Numbers and Addresses"* sub-section. Details regarding the complaints, grievance, and appeals resolution process are provided in the *"Complaint, Grievance and Appeal Processes"* Section.

If any Member or former Member files any action or Complaint regarding services received by the Member *(Including, without limitation, the filing of a lawsuit, administrative action, or Grievance)* against FHCP or a Contracted Provider, FHCP shall have the right to receive from any health care provider rendering services to the Member or former Member information and records reasonably necessary to investigate the allegations in such action or complaint. This right includes, without limitation, authorization by the Member or former Member for FHCP, or its legal representatives, to discuss the Member's or former Member's condition with, and receive all relevant reports and records from, Contracted Providers and Non-Contracted Providers who provided services to, or consulted with, the Member or former Member as a result of injuries alleged in any action or complaint, even if such services or consultations are provided subsequent to termination of Membership. The authorization set forth in this Section survives the termination of coverage by FHCP.

Compliance with State and Federal Laws and Regulations

The terms of coverage and/or benefits to be provided by FHCP under the Group Plan 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 a Member, the Group, or FHCP.

Confidentiality

Except as otherwise specifically provided herein the Group Plan, and except as may be required in order for FHCP to administer coverage and/or benefits under the Group Plan, specific medical information concerning Members received by Contracted Providers shall be kept confidential by FHCP. Such information shall not be disclosed to third parties without the written consent of the Member involved, except for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and/or benefits under the Group Plan, specifically including FHCP's quality assurance and utilization review activities. Additionally, FHCP may disclose such information to entities affiliated with FHCP as well as governing State and Federal Agencies and/or Accreditation Organizations as required by State Statutes.

However, any documents or information which is properly subpoenaed in a judicial proceeding, or by order of a regulatory agency, shall not be subject to this provision.

FHCP's financial arrangements with Contracted Providers may require that FHCP release certain claims and medical information about Members even if the Member has not sought treatment by or through that provider. By accepting Membership, each Member hereby authorizes FHCP to release to its Contracted Providers claims information, including related medical information, pertaining to the Member, in order for the Contracted Providers to evaluate financial responsibility under their contracts with FHCP.

Evidence of Coverage

Each Subscriber will be provided with a Certificate of Coverage and a Membership Card for enrolled Members and their eligible Dependents. Possession of Certification of Coverage and/or Membership Card does not guarantee coverage and/or benefits herein.

Governing Law

The terms of coverage and/or benefits to be provided by FHCP under the Group Plan and the rights of the parties hereunder shall be construed in accordance with the laws of the State of Florida and/or the United States, when applicable.

Membership Cards

The Membership Cards issued to Members in no way create, or serve to verify, eligibility to receive coverage and/or benefits hereunder.

Modification of Provider Network

The FHCP provider network is subject to change at any time without prior notice to, or approval of, the Group or any Member. Additionally, FHCP 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 of, the Group or any Member.

Non-Waiver of Defaults

Any failure by FHCP at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions set forth herein, shall in no event constitute a waiver of any such terms or conditions. Further, it shall not affect the right of FHCP at any time to enforce or avail itself of any such remedies as it may be entitled to under applicable law.

Notices

Any notice required or permitted hereunder shall be deemed given if hand delivered or if mailed by United States Mail, postage prepaid, and addressed as set forth below. Such notice shall be deemed effective as of the date delivered or so deposited in the mail.

If to FHCP:
To the address printed on the Group Application and/or the Membership Card.

If to Member:
To the latest address provided by the Member or to the Subscriber's latest address on the Individual Application for Group Insurance/Membership or Change of Address form actually delivered to FHCP.

If to Group:
To the address indicated on the Group Application.

Obligations of FHCP upon Individual's Termination

Upon termination of an individual's Membership for any reason, FHCP shall have no further liability or responsibility under the Group Plan with respect to such individual, except as specifically set forth herein.

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 Certificate of Coverage.

Florida Agency for Health Care Administration Performance Data

The performance outcome and financial data published by Florida's Agency for Health Care Administration (AHCA), pursuant to Section §408.05, *Florida Statute* or any successor statute, located at AHCA;s web site:

https://ahca.myflorida.com/**Third Party Beneficiary**

The Master Policy under which this Certificate of Coverage was issued was entered into solely and specifically for the benefit of FHCP and the Group. The terms and provisions of the Master Policy shall be binding solely upon, and inure solely to the benefit of, FHCP and the Group, and no other person shall have any rights, interest or claims thereunder, or under this Certificate of Coverage, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. FHCP and the Group hereby specifically express their intent that health care providers that have not entered into contracts with FHCP to participate in FHCP's provider networks shall not be third-party beneficiaries under the Master Policy or this Certificate of Coverage unless the Group or Members in the Group have elected a Point-of-Service (POS) or Triple Option Plan.

Section 15: Covered Services Introduction

The Section that follows describes the Medical Services for which expenses are covered under the Group Plan. **It is very important that these Sections be reviewed with the *"Exclusions and Limitations"* Section and other provisions of this Certificate of Coverage**. Important information is also contained in your Plan *"Summary of Benefits and Coverage"* and "*Schedule of Benefits"*. The level of coverage and/or benefits for certain Covered Services depends on whether the Member has followed the Coverage Access Rules (See the *"Coverage Access Rules"* Section) and the Member's type of Plan.

ALL PROVISIONS OF THIS CERTIFICATE OF COVERAGE SHOULD BE READ CAREFULLY TO UNDERSTAND THE COVERAGE PROVIDED.

Covered Services

Expenses for the Health Care Services listed below will be covered under the Group Plan only if the services are:

1. Within the service categories set forth in the Covered Services Sections;
2. Medically Necessary;
3. Rendered while coverage is in force;
4. Not specifically limited or excluded; and
5. Received in accordance with the Coverage Access Rules.

Applicable Copayments, coinsurance and/or deductible for which the Member is responsible for each category of Covered Services are set forth in the *"Summary of Benefits and Coverage"* and *"Schedule of Benefits."*

Medical Necessity

Except for any preventive care benefits specifically described in the Covered Services Sections, FHCP does not cover or provide benefits for any service which is otherwise covered if, in the opinion of FHCP, such service is not Medically Necessary, as defined in the *"Glossary"* Section. **FHCP will make Medical Necessity decisions for coverage and payment purposes only**. In some instances, these decisions are made by FHCP after the Member has been hospitalized or has received other Health Care Services and after a claim for payment has been submitted.

FHCP's Medical Necessity decisions under this Certificate of Coverage are solely for the purpose of coverage or payment. In this respect, FHCP may review medical facts in making a coverage or payment decision. However, all decisions that require or pertain to independent professional medical judgment or training, or the need for medical services, must be made solely by the Member and the Member's treating Physicians.

It is possible that a Member or the Member's treating Physician may conclude that a particular service is beneficial, appropriate, or desirable even though expenses for such service may be denied as not being Medically Necessary and/or a Covered Benefit.

Point-of-Service (POS) and Triple Option Members

For Members with a Point-of-Service (POS) or Triple Option Plan, all Covered Services Sections and "*Exclusions and Limitations"* Section of this Certificate of Coverage still apply. The cost of these services will depend upon the Provider utilized. When you utilize a Contracted Provider your claim(s) will be processed at the Maximum, HMO Benefit Level minus the applicable HMO copayment, coinsurance, and/or deductible**. Utilization of Non-Contracted Providers, except for emergency or urgently needed care, will result in a higher financial responsibility on your part; higher copayment, coinsurance and/or deductible, plus any applicable balance billing.**

(See your "*Summary of Benefits and Coverage"* and *"Schedule of Benefits."*)

Routine services by a Non-Contracted Provider are paid at the HMO Benefit Level **ONLY** upon Prior Authorization approval by FHCP that specifically states the service(s) requested have been approved at the HMO rate.

Emergency and urgently needed care services rendered by any Provider, regardless of contract status will be paid at the HMO benefit rate.

Section 16: Covered Medical Services

The following Medical Services may be Covered Services, subject to the Copayments, Coinsurance and/or Deductible as applicable (see your *"Summary of Benefits and Coverage" and "Schedule of Benefits"*), **when provided to a Member by Contracted Providers and in accordance with the rules set forth in the *"Coverage Access Rules"* Section:**

Note: Members with a Point-of-Service or Triple Option Plan, when you utilize a Contracted Provider your claim(s) will be processed at the Maximum, HMO, Benefit Level minus applicable HMO Copayment, Coinsurance, and/or Deductible. **Utilization of Non-Contracted Providers, except for emergency or urgently needed care, will result in a higher financial responsibility on your part; higher copayment, coinsurance and/or deductible, plus any applicable balance billing.**

(See your "*Summary of Benefits and Coverage" and "Schedule of Benefits."*)

Accidental Dental Care

Dental Services rendered within 6 months of an Accidental Dental Injury provided such Services were for the treatment of damage to Sound Natural Teeth, resulting from an Accidental Dental Injury occurring while a Member of FHCP. See the definition of Accidental Dental Injury in the "*Glossary" S*ection.

Allergy Treatment:

Including testing and desensitization therapy *(e.g., injections)*, including cost of hypo-sensitization serum.

Ambulance Services

Provided by a ground vehicle may be covered provided it is necessary to transport you from:

1. The place a medical emergency occurs to the nearest hospital that can provide proper care;
2. A Hospital that is unable to provide proper care to the nearest Hospital that can provide proper care; and
3. A Hospital to a Skilled Nursing Facility.

Expenses for Ambulance Services by a boat, airplane or helicopter may be allowed if; the travel distance is inaccessible by ground transport; speed in excess of ground transport speed is critical; or the travel distance involved in getting you to the nearest Hospital that can provide care is too far for medical safety as determined by FHCP. (See the *"Exclusions and Limitations"* Section.)

Ambulatory Surgical Center (ASC) Services

The following Health Care Services may be covered when provided at a Contracted Ambulatory Surgical Center *(ASC)* for a Member. These services require Prior Authorization by FHCP and are subject to the copayment, coinsurance, and/or deductible, as applicable. (See your Plan *"Summary of Benefits and Coverage"* and *"Schedule of Benefits."*)

Such services may include:

1. Use of operating and recovery rooms;
2. Respiratory therapy (e.g., oxygen);
3. Drugs and medicines administered at the Ambulatory Surgical Center;
4. Intravenous solutions;
5. Dressings, including ordinary casts;
6. Anesthetics and their administration;
7. Administration and cost of whole blood or blood products;
8. Transfusion supplies and equipment;
9. Diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing *(e.g., EKG)*;
10. Chemotherapy treatment for proven malignant disease; and
11. Other Medically Necessary Services.

Note: **Members with a Point-of-Service or Triple Option Plan**: These services are subject to Pre-Certification. When you utilize a Contracted Provider your claim(s) will be processed at the Maximum, HMO Benefit Level minus applicable HMO copayment, coinsurance, and/or deductible. **Utilization of Non-Contracted Providers, except for emergency or urgently needed care, will result in a higher financial responsibility on your part; higher copayment, coinsurance and/or deductible, plus any applicable balance billing**.

(See your "*Summary of Benefits and Coverage"* and *"Schedule of Benefits."*)

Anesthesia Services for Dental Care

Including general anesthesia and hospitalization services necessary to assure the safe delivery of necessary dental care provided to a Member in a Hospital or Ambulatory Surgical Center if:

1. The Member is under 8 years of age when it is determined by a dentist and the Member's Primary Care Physician or a Contracted Specialist that dental treatment is necessary due to a dental condition that is significantly complex, or the Member has a developmental disability in which patient management in the dental office has proved to be ineffective; or

2. The 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 Surgical Center.

Anesthesia Services for Medical Care

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, payment for Covered Services, if any, will be made for both the CRNA and the Physician Health Care Services at the lower directed services Allowed Amount in accordance with FHCP's payment program for such Covered Services then in effect.

Autism Spectrum Disorders

Pervasive Developmental Disorder *(not otherwise specified);* Child Disintegrative Disorder; and Down's Syndrome. (S*ee* "*Glossary*" Section for full definition of related diagnoses.)

Autism Spectrum Disorders; Pervasive Developmental Disorder *(not otherwise specified)*; Childhood Disintegrative Disorder; and Down's Syndrome Services provided to a Dependent who is under the age of 18, or if 18 years of age or older, is attending high school and was diagnosed with Autism Spectrum Disorder prior to his or her 9th birthday. Available services are as follows:

1. Well-baby and well-child screening for the presence of Autism Spectrum Disorders Pervasive Developmental Disorder *(not otherwise specified)*; Childhood Disintegrative Disorder; and Down's Syndrome;
2. Applied Behavior Analysis, when rendered by an individual certified pursuant to Section §393.17, *Florida Statutes* or licensed under Chapters 490 or 491 of the *Florida Statutes*; and
3. Physical Therapy by a Physical Therapist. Occupational Therapy by an Occupational Therapist and Speech Therapy by Speech Therapist.

Payment Guidelines for Autism Spectrum Disorders; Pervasive Developmental Disorder *(not otherwise specified);* Child Disintegrative Disorder; & Down's syndrome:

1. Autism Spectrum Disorders Pervasive Developmental Disorder *(not otherwise specified)*; Childhood Disintegrative Disorder; and Down's syndrome Services must be provided in our Service Area by Contracted Providers and authorized by FHCP in accordance with criteria established by FHCP, before such services are rendered. Services performed without Prior Authorization from FHCP will be denied.

2. All covered services for Autism Spectrum Disorders; Pervasive Developmental Disorder (not *otherwise specified)*; Childhood Disintegrative Disorder; & Down's Syndrome will be processed according to *Florida Statues (§627.6686 & §641.31098)* and will be applied to the Calendar Year and Lifetime Benefit Maximum as follows:

   a. $36,000 annual maximum allowable.

   b. The lifetime benefit maximum for Autism Spectrum Disorders; Pervasive Developmental Disorder *(not otherwise specified)*; Childhood Disintegrative Disorder; & Down's Syndrome services will be adjusted annually on January 1st or each calendar year to reflect any change from the previous year in the medical component of the then, current Consumer Price Index for all urban consumer, published by the United States Department of Labor.

Note: In order to determine whether such Services for Autism Spectrum Disorders; Pervasive Developmental Disorder *(not otherwise specified)*; Childhood Disintegrative Disorder; and Down's Syndrome are covered under this Certificate of Coverage, FHCP reserves the right to request a formal treatment plan signed by the treating Contracted Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

Breast Reconstructive Surgery and implanted prostheses, incident to Mastectomy.

The term "Breast Reconstructive Surgery" means surgery to re-establish symmetry between the two breasts after a mastectomy. To be covered, such surgery must be in a manner chosen by the Member's contracted Physician, consistent with prevailing medical standards, and in consultation with the Member.

Casts, Braces, Splints, and Trusses

When provided as part of treatment in a health care provider facility, office, or in a Hospital emergency room. This does not include the supply of, or replacement of, dental splints or trusses.

Child Cleft Lip and Cleft Palate Treatment Services:

Medical, Dental, Speech Therapy, Audiology, and Nutrition services for treatment of a child under the age of 18 who has cleft lip or cleft palate. In order for such services to be covered, the Member's Primary Care Physician, or a Contracted Specialist, must specifically:

1. Prescribe such services; and
2. Certify, in writing, that the services are Medically Necessary and consequent to treatment of the cleft lip or cleft palate.

Child Health Supervision Services:

Certain periodic Physician-delivered or Physician-supervised services that are provided to a Dependent from the moment of birth up to the 17th birth date are Covered Services as follows:

1. 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;
2. Oral and/or injectable immunizations; and
3. Laboratory tests normally performed for a well-child.

These Covered Services shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics, the U.S. Preventive Services Task Force (USPSTF), or the U.S. Advisory Committee on Immunization Practices established under the Public Health Services Act.

Chiropractic Treatment

Non-surgical spine and back disorder treatments consisting of Medically Necessary manipulations of the spine to correct a slight dislocation of a bone or joint that is demonstrated by X-ray.

Clinical Trials

FHCP will cover Routine, In-Network Member costs ONLY for Members enrolled in a Phase I, II, III, or IV of an approved Clinical Trial if it is:

1. Conducted for prevention, detection or treatment of cancer or another life-threatening disease or condition likely to lead to death unless the course of the disease or condition is interrupted and it is:
    a. Federally funded or approved by: The National Institute of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHRQ), the Center for Medicare and Medicaid Services (CMS), a cooperative group or center of any of the entities listed here, the Department of Defense (DOD) or the Department of Veterans Affairs (DVA), or a non-governmental research entity identified in the NIH guidelines for Center support grants;
    b. Is either conducted under an Investigational New Drug application (IND) reviewed by the FDA (See the *"Glossary"* Section);
    c. A drug trial that is exempt from the IND application requirements; or

d. An Investigational Device Exemption (IDE) trial of an FDA "Category A" IDE (*experimental*) device or FDA "Category B" IDE *(Non-experimental / investigational)* pre-market Device.

In addition to the above, for a Member to be entitled to **Routine, In-Network Benefits,** the Member must:

1. Be a **qualified patient** meeting the trial protocol of an approved Clinical Trial; and
2. The Member's attending Physician **MUST obtain Prior Authorization from FHCP** and include documentation that the Member's participation in the Clinical Trial is appropriate or must provide medical and scientific information establishing that the Member meets the Clinical Trial protocol and the Member's participation is appropriate.

Routine, in-network Member costs include all items and services that FHCP would cover under the Member's Group Plan if the Member was not enrolled in a Clinical Trial.

Items, devices, and services that are investigational; and items and services that are solely for the purpose of data collection and analysis and not for direct clinical management of the Member or are inconsistent with established standards of care for the Member's diagnosis are NOT routine and will not be covered under the Group Plan. (*See the* "*Exclusions and Limitations"* Section.)

Note: Members with a Point-of-Service or Triple Option Plan: Participation in the Clinical Trial will require Prior Authorization from FHCP. Certain routine services associated with the Trial may also require Prior Authorization from FHCP. When you utilize a Contracted Provider your claim(s) will be processed at the Maximum, HMO Benefit Level minus applicable HMO copayment, coinsurance, and/or deductible. **Utilization of Non-Contracted Providers, except for emergency or urgently needed care, will result in a higher financial responsibility on your part; higher copayment, coinsurance and/or deductible, plus any applicable balance billing.**

(See your "*Summary of Benefits and Coverage"* and *"Schedule of Benefits."*)

Circumcision

When performed by a physician as part of newborn care prior to discharge; as an outpatient in an Ambulatory Surgery Center or Outpatient Hospital facility; and in a physician's office. The applicable cost-sharing will apply in accordance with the setting where the procedure is performed.

Congenital or Developmental Deformity:

Diagnostic and Surgical Procedures for corrections of a congenital or developmental deformity if, under acceptable medical standards such procedure or surgery is medically necessary to treat conditions caused by Congenital or Developmental Deformity, Disease or injury.

Note: Routine treatment of teeth or gums, intra-oral prosthetic devices ***(With the exception of those devices approved by the FDA to treat a confirmed medical condition (e.g., TMJ and Sleep Apnea) and NOT available over the counter)*** and/or surgical procedures for cosmetic purposes are excluded. (See the *"Exclusions and Limitations"* Section.)

Dermatology Services

Limited to the following: Medically Necessary minor surgery, tests, and office visits provided by a Dermatologist who is a Contracted Provider for a maximum of five (5) visits within a Calendar Year without an authorization. **Any services rendered above these five (5) visits require Prior Authorization from FHCP**.

Diabetes Treatment Services and Supplies

Covered Services include diabetes outpatient self-management training and educational services and nutrition counseling, including all medically appropriate and necessary insulin and equipment and supplies, when used to treat diabetes, if the Member's Primary Care Physician, or a Contracted Specialist who specializes in the treatment of diabetes, certifies that such services are necessary. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of an FHCP certified Diabetes Care and Education Specialist or a board-certified Physician specializing in endocrinology. In order to be covered under this Agreement, nutrition counseling must be provided by a licensed FHCP contracted dietitian.

The following Diabetic Supplies are available and listed in your "*Medical Pharmacy Formulary":*

1. Standard Glucometer;
2. Lancets *(box of 100);*
3. Test Strips *(box of 50); and*
4. Continuous Glucose Monitor System (*CGM*) and sup*plies (e.g. sensors and transmitters)*. Prior Authorization by FHCP is required.

(*See your "Medical Pharmacy Formulary," "Summary of Benefits and Coverage, and Schedule of Benefits*.")

Note: Specialized Diabetic supplies such as insulin pumps and pump supplies require Prior Authorization from the Plan and are subject to applicable DME or Medical Pharmacy cost-sharing.

Diagnostic Services

Including advanced imaging *(e.g., CT Scans, MRI, MRA, PET*) radiology, ultrasound, laboratory, pathology, approved machine testing *(e.g., electrocardiogram (EKG))*. Diagnostic Services involving bones or joints of the jaw and facial region if, under accepted medical standards, such diagnostic services are Medically Necessary to treat conditions caused by congenital or developmental deformity, disease, or injury. Pet Scans ordered by a Primary Care Physician require Prior authorization by FHCP.

IMPORTANT: Always refer to the "*Types of Services that Require Prior Authoriz*ation" sub-section and the "*Covered Access Rules*" Section. There are certain types of diagnostic services that require Prior Authorization from FHCP.

Dialysis Treatment

Outpatient dialysis program services rendered at a certified Dialysis Center.

Drugs

See "*Medical Pharmacy*" in this Section and the *"Prescription Drug Coverage*" Section.

Durable Medical Equipment

Durable Medical Equipment which has been prescribed by the Member's Primary Care Physician, or a Contracted Specialist and which is considered a Medically Necessary Covered Service. FHCP reserves the right to rent or purchase the most cost-effective durable medical equipment which meets the Member's needs. If the cost of renting is more than its purchase price, only the cost of the purchase is considered a Covered Service. Supplies and services to repair medical equipment, which have been authorized by FHCP, may be a Covered Service only if the Member owns the equipment or is purchasing the equipment, or when necessitated due to growth of a Dependent child or due to change in the Member's condition.

The wide variety of durable medical equipment and continuing development of patient care equipment makes it impractical to provide a complete listing of covered Durable Medical Equipment. However, some Durable Medical Equipment has been specifically excluded. Please refer to the *"Exclusions and Limitations"* Section.

Emergency Services and Urgently Needed Care Worldwide

IN THE EVENT OF AN EMERGENCY, GO TO THE NEAREST HOSPITAL OR CLOSEST EMERGENCY ROOM OR CALL 911.

Emergency Services and Care provided in a Hospital's Emergency Department or Stand-alone Emergency Center (See *"Glossary"* Section**)** in or out of the Service Area shall be Covered Services without prior notification to FHCP, subject to the copayment, coinsurance, and/or deductible, as applicable. (See your *"Summary of Benefits and Coverage"* and *"Schedule of Benefits"*). It is the Member's responsibility, however, to notify both FHCP and their Primary Care Physician as soon as possible, concerning the receipt of Emergency Services and Care and/or any admission which results from an Emergency Medical Condition. If a determination is made that an Emergency Medical Condition does not exist, payment for services rendered subsequent to that determination will be the responsibility of the Member.

Follow-up care must be rendered by a Primary Care Physician or a Contracted Specialist. If the follow-up care is provided by other than a Primary Care Physician or Contracted Specialist, coverage may be denied.

Payment for Emergency Services and Care rendered by Non-Contracted Providers will be the lesser of the provider's charges, the usual and customary provider charges for similar services in the community where the services were provided, or the charge mutually agreed to by FHCP and the provider within 30 days of the submittal of the claim for such Emergency Services and Care. It is the responsibility of the Member to furnish to FHCP written proof of loss in accordance with the *"Claims Review"* Section.

Urgently Needed Services and Care

When in our Service Area the Member should first attempt to contact their Primary Care Physician to discuss their symptoms before seeking treatment at a Contracted Urgent Care Facility. When outside of our Services Area such services may be Covered Services without prior notification to FHCP. Covered Urgently Needed Care services rendered in the Primary Care Physician's Office or an Urgent Care Facility is subject to the appropriate Urgent Care copayment, coinsurance, and/or deductible, as applicable. (See your "*Summary of Benefits and Coverage"* and *"Schedule of Benefits*.")

It is the Member's responsibility, to notify both FHCP and their Primary Care Physician as soon as possible, concerning the receipt of Urgently Needed Services and Care. If a determination is made that an Urgent Medical Condition does not exist, payment for Services rendered subsequent to that determination will be the responsibility of the Member.

Enteral Formulas

Total Parenteral Nutrition (TPN) formulas that are prescribed by a Primary Care Physician or a Contracted Specialist, are Medically Necessary, and administered in a hospital setting, or by properly licensed clinician as part of FHCP approved Home Health Care Services, or in a Skilled Nursing Facility setting or other clinical setting *(e.g., Infusion Clinic)* are covered medical services.

Enteral nutrition products that are administered by means of a feeding tube and are Medically Necessary to maintain weight and strength are covered. Prior Authorization from FHCP is required.

Nutrition Formulas and Supplements that are available over the counter *(OTC)* or those Nutritional Formulas and Supplements that do not require administration by an appropriately Licensed Clinical Professional are not covered.

Gender Dysphoria & Sexual Reassignment / Modification

IMPORTANT: The following services related to Gender Dysphoria *(#'s 1–3 inc. 3a-n)* are available ONLY to Members in all new plans *and "Non-Grandfathered Plans" (any Plan written by FHCP on or after March 23, 2010)*. (See "*Glossary*" Section for a definition of a "*Non-Grandfathered Plan*").

To be covered, the following services related to sexual re-assignment or modification must meet Medical Necessity Criteria and require Prior Authorization from FHCP:

1. Hormone Therapy;
2. Psychological / Behavioral Health Therapy; and
3. Sexual re-assignment procedure(s). When medical necessity criteria is met and prior authorization from FHCP has been obtained the following procedures may be covered:
    a. Clitoroplasty;
    b. Hysterectomy;
    c. Metoidioplasty;
    d. Orchiectomy;
    e. Penectomy;
    f. Penile prosthesis;
    g. Phalloplasty;
    h. Salpingo—oophorectomy;
    i. Scrotoplasty;

j. Testicular prosthesis;

k. Urethroplasty;

l. Vaginectomy;

m. Vaginoplasty; and

n. Vulvectomy.

Reversals of sexual re-assignment procedures, Cosmetic procedures, and/or complications from such procedure(s) are NOT covered and are excluded under the Plan. *(*See the *"Exclusions & Limitations"* Section*.)*

NOTE: Members with a Point of Service (POS) or Triple Option Plan: These services will **ONLY** be covered when **Prior Authorization by FHCP has been obtained**.

Hearing Exam:

When performed by a contracted licensed audiologist for the sole purpose of determining and measuring functional hearing loss. Hearing aids are not covered by FHCP. See the "Exclusions and Limitations" Section.

Home Health Care

To be covered, Prior Authorization by FHCP is required.

Home Health Care Services must be provided by a contracted Home Health Care Agency in FHCP's Service Area and all of the following conditions must be met:

1. The Primary Care Physician or Contracted Specialist submits a written treatment plan to FHCP;
2. FHCP approves the written treatment plan; and
3. The Member is confined to home and the services being provided are in lieu of hospitalization, continued hospitalization, or confinement in a skilled nursing facility.

The services must be provided by a Home Health Agency, through a Licensed Nurse Registry, or by an Independent Nurse licensed under *Florida Statutes*:

1. Part-time or intermittent skilled nursing care, by a Registered Nurse or Licensed Practical Nurse;
2. Physical Therapy, by a Licensed Physical Therapist;
3. Occupational Therapy, by a Licensed Occupational Therapist;
4. Speech Therapy, by a Licensed Speech Therapist;
5. Medical Social Services when provided in consult with FHCP's Certified Social Worker;
6. Nutritional guidance;

7. Medical appliances, equipment, laboratory services, supplies, drugs and medicines when prescribed by a Physician provided by or for the Home Health Agency; and
8. Respiratory or inhalation therapy *(e.g., oxygen).*

The following Home Health Care Services are NOT Covered under the Group Plan:

1. Homemaker Services;
2. Domestic maid Services;
3. Sitter Services;
4. Companion Services;
5. Services rendered by an employee or operator of an adult congregate living facility; an adult foster home; and adult day care center, or a nursing home facility; and
6. Custodial Care.

Note: Your Group Plan may include limitations on the number of visits available per calendar year for Home Health Care Services. See your *"Summary of Benefits and Coverage"* and *"Schedule of Benefits"* for any limitations on specific services that are not otherwise noted in this Certificate of Coverage.

Hospice Services

Home Care: When available in the Service Area, Hospice Home Care will be provided as part of a Hospice program approved by FHCP, limited to those Outpatient Services which are Covered Services.

Hospice Outpatient Care: Outpatient Services which are Covered Services, when received while the Member is in a Hospice outpatient program approved by FHCP.

Hospice Inpatient Care: Inpatient Services which are Covered Services received while the Member is in a Hospice program approved by FHCP and the inpatient status is Medically Necessary, as determined by FHCP.

Note: Covered Hospice Services do not include bereavement counseling, pastoral counseling, financial or legal counseling, and/or custodial care. The Hospice Treatment Program must meet the standards outlined by the National Hospice Association, be recognized as an approved Hospice Program, be licensed, certified, and registered as required by Florida Law, and be directed by a Physician in consultation with the Member's Primary Care Physician.

Hospital Services

Hospital Services provided at Contracted Hospitals for a Member. A Member may access these services by utilization of an admission as the result of presenting to an Emergency Room and/or as directed or ordered by their Physician. These services may require Prior

Authorization by FHCP as explained in the "*Coverage Access Rules"* Section and are subject to the copayment, coinsurance and/or deductible, as applicable (see your "*Summary of Benefits and Coverage"* and *"Schedule of Benefits"*). Such services may include:

1. Room and board in a semi-private room, unless the patient must be isolated from others for documented clinical reasons;
2. Intensive care units and other specialized units for documented clinical reasons including cardiac, progressive, and neonatal care;
3. Use of operating and recovery rooms;
4. Use of emergency rooms;
5. Respiratory therapy (e.g., oxygen);
6. Drugs and medicines administered by the Hospital;
7. Intravenous solutions;
8. Administration and cost of whole blood or blood products;
9. Dressings, including ordinary casts;
10. Anesthetics and their administration;
11. Transfusion supplies and equipment;
12. Diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
13. Chemotherapy treatment for proven malignant disease;
14. Physical Therapy (in connection with a covered Condition);
15. Other Medically Necessary Services; and
16. Transplants as set forth in the *"Transplant Services"* in the *"Covered Medical Services"* Section.

Services rendered at Non-Contracted Hospitals will be covered as outlined above for Emergency care only, unless, Prior Authorization has been obtained from FHCP before the services are rendered.

Note: **Members with a Point-of-Service or Triple Option Plan**: These services may require Pre-Certification. When you utilize a Contracted Provider your claim(s) will be processed at the Maximum, HMO Benefit Level minus applicable HMO copayment, coinsurance, and/or deductible. **Utilization of Non-Contracted Providers, except for emergency or urgently needed care, will result in a higher financial responsibility on your part; higher copayment, coinsurance, and/or deductible, plus any applicable balance billing. (**See your "*Summary of Benefits and Coverage" and "Schedule of Benefits.")*

Infertility Services

Services for the diagnosis and treatment of infertility are **not covered.** See the "*Exclusions and Limitations*" Section.

Laboratory Services

Routine blood work when performed at a contracted laboratory. **Specialized studies such as genetic testing require Prior Authorization from FHCP** (also see "*Diagnostic Services"* in this Section).

Mammogram Screening Services

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

1. A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age;
2. A mammogram every two years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based upon a Physician's recommendation;
3. A mammogram every year for any woman who is 50 years of age or older; or,
4. One or more mammograms a year, 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 mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before age 30.

Except for mammograms done more frequently than every two years for women 40 years of age or older, but younger than 50 years of age, Covered Services are payable, with or without a prescription from a Physician, when the Member obtains a mammogram in a medical office, medical treatment facility or through a health testing Service that uses radiological equipment registered with the appropriate Florida regulatory agencies for breast cancer screening. Covered Services are subject to all other terms and conditions applicable to other Covered Services.

Mastectomy Services

For breast cancer treatment, treatment for physical complications for all stages of Mastectomy including lymphedemas, and outpatient post-surgical follow-up in accordance with prevailing medical standards in a manner determined in consultation with the attending Physician and the Member. "Mastectomy" means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician. Outpatient post-surgical follow-up care for Mastectomy Services shall be covered when provided by a Contracted Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital,

Physician's office, outpatient center, or home of the Member. The treating Physician, after consultation with the Member, may choose the appropriate setting.

Maternity Care:

Physician services provided to a Member for normal pregnancy, delivery, miscarriage, or pregnancy complications within the FHCP Service Area ONLY, unless the need for such services was not, and could not, reasonably have been anticipated before leaving the Service Area.

Routine office visits to a Primary Care Physician or contracted specialist for pre- and post-natal care.

Health Care Services, including prenatal care, delivery, and postnatal care, provided to a Member. Care for a mother and her newborn infant including post-partum assessment and newborn assessment may be provided at the Hospital. These services include physical assessment of the newborn and mother, and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards. *(*Also see "*Hospital Services*" Section.)

Services for pre- and post-natal care for a mother and her newborn at the attending Physician's office, at a Birthing Center or in the home by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Midwife or Certified Nurse Midwife MUST have Prior Authorization approval by FHCP.

Inpatient Hospital Services provided to a Member for normal pregnancy, delivery, miscarriage, or pregnancy complications are covered when provided **within the FHCP Service Area ONLY** (*Florida Counties of Brevard, Flagler, Seminole, St. Johns*, *and Volusia)* unless the need for such Services was not, and could not reasonably have been, anticipated before leaving the Service Area.

Under Federal law, a Group Plan generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn. Guidelines indicate a minimum stay of 48 hours for a normal vaginal delivery and a minimum stay of 96 hours for a delivery via C-Section.

Medical Pharmacy

These services consist of certain medications listed in a dedicated "*Medical Pharmacy Formulary"* and are covered under the medical benefits of the Plan and not a prescription drug benefit. Types of "*Medical Pharmacy*" Medications include:

> *Medications that are required to be administered by a health care provider professional such as a Physician, ARNP, PA, RN in an office or other outpatient setting. These types of medications include injectable antibiotics, chemotherapy, and certain vaccinations received as part of preventive care.*

Any prior authorization, step therapy, quantity limitations or other requirements applicable to a medication will be listed in the "*Medical Pharmacy Formulary*." If the medication /

drug treatment being proposed is not listed in this Formulary your treating physician may request a formulary exception through FHCP's Referral Department.

Note: See your "*Summary of Benefits and Coverage*" and "*Schedule of Benefits*" for cost-sharing information**.**

Newborn Childcare:

Covered Services applicable for children shall be provided with respect to a newborn child of a Member from the moment of birth provided that the newborn child is properly enrolled. Covered Services for a covered newborn child shall consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity.

Care for a newborn child may be provided at the Hospital, at the attending Physician's office, at a Birthing Center, or in the home by a Physician, Midwife, or Certified Nurse Midwife. These services include physical assessment of the newborn child, and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards.

Services for pre- and post-natal care for a newborn at the attending Physician's office, at a Birthing Center or in the home by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Midwife or Certified Nurse Midwife require Pre- Authorization approval by FHCP.

Ambulance services when necessary to transport the newborn child to and from the nearest facility which is appropriately staffed and equipped to treat the newborn child's Condition, as determined by FHCP and certified by the Primary Care Physician or a Contracted Specialist as Medically Necessary to protect the health and safety of the newborn child.

Newborn hearing screenings at birth and medically necessary follow-up re-evaluations leading to a conclusive diagnosis up to the age of 12 months.

Newborn child coverage for ophthalmic ointment to prevent gonococcal ophthalmia neonatorium (GON).

Note: Coverage for a newborn child of a Member other than the Subscriber *(Employee)* or the Subscriber's Dependent Spouse *(e.g., Subscriber's Dependent Child)* will automatically terminate 18 months after the birth of the newborn child unless the Subscriber produces documentation that he or she has:

a. Adopted the newborn child; or

b. Is the court appointed legal guardian or legal custodian of the newborn child.

(See the "*Eligibility Requirements for Dependents"* sub-section of the "*Eligibility for Membership"* Section.)

Osteoporosis Screening

Diagnosis and Medically Necessary treatment of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid *(steroid)* therapy, individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis. Benefit is limited to one (1) screening every twenty-four (24) months. (See the *"Preventive Health Screening"* sub-section for additional information.)

Oxygen

When medically necessary, including the use of equipment for its administration.

Pain Management

Services that have been determined to be medically necessary and in compliance with the standard of practices for Pain Management Clinics when provided in the FHCP Service Area by a Contracted Pain Management Physician or Addiction Medicine Specialist Physician.

Physician Services, Medical and Surgical care

Whenever provided in a Physician's office, a Hospital, an Ambulatory Surgery Center, or a Skilled Nursing Facility. Both Specialist and Primary Care Physician Services are available.

Prescription Drug Service

This applies to Members enrolled in Group Plans with a Prescription Drug Benefit: See the "*Pharmacy Drug Coverage*" Section of this COC that includes information on access rules, covered drugs, exclusions and limitations. Copayments, Coinsurance and/or Deductibles, are disclosed in detail in the *"Summary of Benefits and Coverage"* and *"Schedule of Benefits."* Additional information can be found in the *"Prescription Drug Formulary."*

Note: This is not the same as Medical Pharmacy. All Group Plans include a Medical Pharmacy Benefit.

Preventive Health Services

These Services are based on standards established by national guidelines such as the Guide to Clinical Preventive Services, recommendations of the U.S. Preventive Services Task Force (USPSTF), National Institute of Health (NIH), the American Cancer Society (ACS) and the Centers for Disease Control and Prevention (CDC).

Payment for Preventive Health Services will only be made when rendered by the Member's Primary Care Physician, at an FHCP Facility, or Preferred Pharmacy location. Only Flu Shots are also available at a Non-Preferred Pharmacy location. Any other type of vaccine/immunization received at a Non-Preferred Pharmacy will be subject to the Member's applicable Non-Preferred Pharmacy cost-sharing.

The following link https://www.healthcare.gov/coverage/preventive-care-benefits/ will provide you with a comprehensive listing of the most current USPSTF A & B Preventive Services along with the guidelines and recommendations for each of the services listed. This listing is subject to change as determined by the USPSTF. Services may be added, guidelines changed, and in some instances, a recommended service may be removed from the list.

It is important to understand that your coverage for these Preventive Services is based on your Group Plan's "*Effective Date*." If there are additions or changes to these recommendations or guidelines after your "*Effective Date;"* your coverage will not change until your Group Plan's next "*Anniversary / Renewal Date"* which may be up to one year after the recommendations or guidelines went into effect:

(See your "Summary of Benefits and Coverage" and "Schedule of Benefits.")

Prosthetic and Medical Brace Devices

Coverage includes the following, when authorized in advance by FHCP and arranged by a Primary Care Physician or a Contracted Specialist:

The prosthetic devices listed below require prior authorization from FHCP. If more than one device can meet the Member's functional needs, benefits are available for the prosthetic that is determined by FHCP to be the most cost effective and attempts to address the Member's basic functional requirements. If the Member or the Member's Physician request a prosthetic device that exceeds the cost of the prosthetic approved by FHCP the benefits payable by FHCP will be limited to the amount FHCP would have paid for the approved prosthetic. The Member shall be responsible for any difference in cost. The prosthetic device must be ordered or provided under the direction of a Physician.

Benefits are available for repairs and replacement for reasonable useful lifetime wear in accordance with nationally recognized guidelines or the Member's needs except that:

a. There is no benefit available for replacement due to misuse, malicious damage or gross neglect; or

b. There are no benefits available for loss.

External Devices: That replace a limb or body part are limited to:

1. Artificial arms, legs, feet and hands;
2. Artificial face, eyes, ears and nose; and
3. Breast prosthesis post mastectomy including bras and lymphedema sleeves for the arm.

Internal Devices: Implantable devices that are part of a prior authorized, pre-certified or emergency surgical procedure including, but not limited to the following FDA approved:

1. Joint replacements;
2. Cardiac pacemakers;
3. Internal cardiac defibrillators;
4. Standard single vision intra-ocular lens;
5. Internal pumps for the purpose of dispensing medications (i.e., chemotherapy drugs);
6. Internal devices for the purpose of pain management; and
7. Post mastectomy breast implants.

The above internal devices are part of a surgical procedure and will be subject to the Member's applicable surgical benefit copayment, coinsurance and/or deductible.

Medical Appliances for Obstructive Sleep Apnea

To be covered, Prior Authorization from FHCP is required.

May be covered when the Member has had a Medical Evaluation, a documented Sleep Study confirming a diagnosis of obstructive sleep apnea and the treating Physician determines that the Member is unable to tolerate a conventional Positive Airway Pressure *(PAP)* Device, or the treating Physician determines that a PAP devise is contraindicated. Medical Appliances, including oral appliances for Obstructive Sleep Apnea, must be FDA approved, must not be available over the counter (OTC).

Note: Benefits may be provided for necessary replacement of a Prosthetic or Medical Brace Device which is owned by the Member when due to irreparable damage, wear, a change in the Member's Condition, or when necessitated due to growth of a Dependent child.

(Also See the "*Exclusions and Limitations"* Section.)

Rehabilitation Services for Medical Conditions

Prescribed short-term inpatient and outpatient Rehabilitation Services are limited to the therapy categories listed below. Your Group's Plan may include limitations on the number of days or visits available per calendar or contract year for Inpatient and/or out-patient rehabilitation services. *(*Also *see Skilled Nursing Facilities* sub-section.)

See your "*Summary of Benefits and Coverage"* and *"Schedule of Benefits"* for any limitations on specific services that are not otherwise noted in this Certificate of Coverage.

Inpatient Rehabilitation

To be covered, Prior Authorization by FHCP is required.

To be approved, all the following conditions must be met:

1. FHCP must review, for coverage purposes only, a Rehabilitation Plan submitted by the Member's Primary Care Physician or a Contracted Specialist;
2. FHCP must agree that the Member's Condition is likely to improve significantly from the first date such Services are to be rendered;
3. Services must be provided to treat functional defects which remain after an illness or injury; and
4. Services must be Medically Necessary for the treatment of a condition and be Pre-Authorized by FHCP.

Rehabilitation Plan

Is a written plan, describing the type, length, duration, and intensity of rehabilitation services to be provided to a Member with rehabilitation potential. Such a plan must have realistic goals which are attainable by the Member within a reasonable length of time and must be likely to result in significant improvement from the first date such services are to be rendered. Rehabilitation Plans for inpatient services will be reviewed periodically by FHCP.

Inpatient Therapies

Rehabilitation Services for Physical, Occupational, Respiratory, and Speech therapy categories provided during a covered inpatient confinement will be covered for the duration of the confinement, as long as these services are Medically Necessary.
(Also see Skilled Nursing Service in this Section.)

Outpatient Rehabilitation

Outpatient rehabilitation must be Medically Necessary services rendered by Contracted Providers which are received by the Member as ordered by the Member's contracted Primary Care Physician or Contracted Specialist The number of available visits may be limited per Member, per year, as noted in the Member's Plan *"Summary of Benefits and Coverage"* and *"Schedule of Benefits."*

Rehabilitation Services are limited to the therapy categories listed below:

Physical/Occupational Therapy

Services of a Physical Therapist or Occupational Therapist for the purpose of aiding in the restoration of normal physical function lost due to illness, injury, stroke or a surgical procedure while this coverage was in force. In order for Physical Therapy or Occupational Therapy to be covered under this provision, such Services must be part of an approved Rehabilitation Plan and provided by a Contracted Provider licensed to render such Services.

Respiratory Therapy

Services of a Respiratory Therapist for the purpose of aiding in the restoration of lung function as part of the treatment plan of a preoperative and post-operative, lung resection or transplant; or, in the event of an acute exacerbation of Chronic Obstructive Pulmonary Disease (COPD) resulting in decreased ability to perform activities of daily living and/or increased dyspnea. These services are usually provided while the Member is in a Hospital or other inpatient Facility setting. If requested on an outpatient basis, such services must be part of a treatment plan submitted to FHCP for Prior Authorization, approved by FHCP, and provided by a Therapist licensed to render such services.

Speech Therapy

Services of a Speech Therapist or Licensed Audiologist as part of a treatment plan to aid in the restoration of speech loss, impairment of speech, or difficulty swallowing, resulting from illness, injury, stroke, or surgical procedure that occurred while this coverage was in force.

Note: Massage Therapy is not covered under the Group Plan.

(See the "*Exclusions and Limitations"* Section.)

Additional Types of Rehabilitation Therapies include:

Cardiac Rehabilitation Phases I & II

Services provided in an outpatient setting for cardiac rehabilitation for the purpose of aiding in the restoration of normal heart function lost due to myocardial infarction, coronary occlusion, or coronary by-pass surgery.

Pulmonary Rehabilitation

Services provided in an outpatient setting for pulmonary rehabilitation the purpose of which is to aid in the restoration of lung function lost due to severe lung condition including but not limited to acute exacerbation of Chronic Obstructive Pulmonary Disease or Post Lung Resection or Transplant Surgery.

Second Medical Opinion

Members who elect to obtain a second medical opinion must notify their Primary Care Physician or Contracted Specialist of their intent to do so.

To be covered, Prior Authorization by FHCP must be obtained before the Second Medical Opinion is rendered.

The Member is entitled to request and to obtain a Second Medical Opinion when the Member disputes either FHCP's or a Contracted Physician's opinion of the reasonableness or necessity of a proposed treatment plan procedure or is subject to a serious injury or illness. A Member may request and obtain a Second Medical Opinion if they feel that they are not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the condition being treated. FHCP also may

require a Member to obtain such a Second Medical Opinion. **In either case, the Member will be required to obtain Prior authorization from FHCP.**

All tests in connection with rendering the Second Medical Opinion, including tests deemed necessary by a Non-Contracted Physician, must be Medically Necessary and must be performed within the FHCP network of Contracted Providers.

Services rendered by a Contracted Provider related to a Second Medical Opinion will be subject to the same copayment, coinsurance, and/or deductible requirement as set forth in the "*Summary of Benefits and Coverage" and "Schedule of Benefits."*

Services rendered by a Non-Contracted Provider within FHCP's Service Area for a Second Medical Opinion are subject to a coinsurance amount equal to 40% of the allowable charge. Members are responsible for the payment of any charges billed by a Non-contracted Provider in excess of the Allowance.

Second Surgical Opinion

Members who elect to obtain a Second Surgical Opinion must notify their Primary Care Physician or Contracted Specialist of their intent to do so.

To be covered, Prior Authorization by FHCP must be obtained before the Second Surgical Opinion is rendered.

The Member is entitled to request and to obtain a Second Surgical Opinion when the Member disputes either FHCP's or a Contracted Physician's opinion of the reasonableness or necessity of a proposed surgical procedure. FHCP also may require a Member to obtain such a Second Surgical Opinion.

In either case, the Member will be required to obtain Prior Authorization from FHCP before the Second Surgical Opinion is rendered.

All tests in connection with rendering the second surgical opinion, including tests deemed necessary by a Non-Contracted Physician, must be Medically Necessary and must be performed within the FHCP network of Contracted Providers.

Skilled Nursing Facilities

Skilled Nursing Facility services are subject to Prior Authorization by FHCP. The Prior Authorization request must be medically necessary, made in writing by a contracted Primary Care Physician or contracted specialist, and approved by FHCP.

Such services may include:

1. Room and board;
2. Respiratory therapy *(e.g., oxygen)*;
3. Drugs and medicines administered while an inpatient;
4. Intravenous solutions;

5. Administration and cost of whole blood or blood products (Except as outlined in the Prescription Drugs exclusion of the *"Exclusions and Limitations*" Section or, if applicable on the Group Plan *Pharmacy* Benefits Sheet;
6. Dressings, including ordinary casts;
7. Transfusion supplies and equipment;
8. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing *(e.g., EKG);*
9. Chemotherapy treatment for proven malignant disease;
10. Physical Therapy *(In connection with a covered Condition)*; and
11. Other Medically Necessary Services.

Benefits for Covered Services at a Skilled Nursing Facility are limited to the number of days per Member, per Calendar Year, set forth in the *"Summary of Benefits and Coverage"* and *"Schedule of Benefits."*

Surgical Assistant Services

When rendered by a Physician or a Physician Assistant acting as a surgical assistant. Surgical assistant services are covered when determined by FHCP that such assistance is Medically Necessary.

Telehealth *(Telemedicine)* Services:

See the *"Limitations"* sub-section of the *"Exclusions and Limitations"* Section.

Third Medical or Surgical Opinions

Are **only** covered when the first two (2) opinions disagree and require Prior Authorization from FHCP.

Transplant Services

Transplants Services as set forth below, if Service is Pre-Authorized by FHCP and if performed at a facility approved by FHCP, subject to the conditions and limitations described below.

Transplant includes pre-transplant, transplant and post-discharge services, expenses related to the donation or acquisition of an organ or tissue for a Member once the donor has been identified and has agreed to donate the organ and treatment of complications after transplantation. FHCP will not pay for donor cost under this Group Plan if those costs are payable in whole or in part by any other insurance carrier, organization or person other than the donor's family or estate. FHCP will pay Covered Services only for services, care and treatment received for or in connection with a:

1. Bone Marrow Transplant as defined in this Certificate of Coverage, which is specifically listed in Chapter 59B-12.001 and as also governed under 59C-1.044 of the *Florida Administrative Code* or covered by Medicare as described in the most recently published *Medicare Coverage Issues Manual* issued by the Centers for Medicare and Medicaid Services. Coverage for the reasonable costs of searching for a donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. Corneal Transplant;
3. Heart Transplant *(Including a ventricular assist device, if indicated, when used as a bridge to heart transplant);*
4. Heart-Lung combination Transplant;
5. Kidney Transplant;
6. Liver Transplant;
7. Lung-whole single or whole bilateral Transplant;
8. Pancreas Transplant; and
9. Pancreas Transplant performed simultaneously with a Kidney Transplant.

For a transplant to be covered, a written Prior Authorization and benefit determination from FHCP is required in advance of the procedure. The Member or the Member's Physician must notify FHCP prior to the Member's initial evaluation for the transplant in order for FHCP to determine if the Transplant services are covered. FHCP must be given the opportunity to evaluate the clinical results of the Member's evaluation. FHCP's benefit determination will be based on the terms of this Certificate of Coverage as well as written criteria and procedures established by FHCP. If prior benefit determination is not given, the transplant will not be covered.

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

1. The Transplant is excluded;
2. FHCP is not contacted for authorization prior to referral for evaluation of the transplant;
3. FHCP does not pre-authorize coverage for the transplant;
4. The expense relates to the transplantation of any non-human organ or tissue;
5. The expense relates to the donation by a Member of an organ or tissue for a recipient who is not covered by FHCP; or
6. The expense relates to the acquisition of an organ or tissue for a recipient who is not covered by FHCP.

The following Services / supplies / expenses are also not covered:

- Any artificial heart or mechanical device that replaces the atrium and/or the ventricle.

Once a coverage decision is made, FHCP will advise the Member or the Member's Physician of the coverage decision. Covered Services are payable only if the pre-

transplant services, the Transplant and post-discharge services are performed in a facility acceptable to FHCP.

For covered Transplants and all related complications, FHCP will cover Hospital expenses and Physician's expenses provided that such services will be paid under "*Hospital Services*" in this Section in accordance with the same terms and conditions for care and treatment of any other covered condition.

Vasectomies - Elective

The following applies to all new plans and "Non-Grandfathered Plans." (See "*Glossary*" Section for a definition of a "*Non-Grandfathered Plan*"). Elective vasectomy is covered in a Physician's office, Ambulatory Surgery Center (ASC), or out-patient department of a hospital. Vasectomies are subject to the applicable copayment, coinsurance and/or deductible.

Note*:* Reversal of a Vasectomy procedure is excluded under the plan. See the *"Exclusions and Limitations"* Section.

Vasectomies - Medically Necessary

The following provision applies to "Grandfathered Plans" ONLY. (See the "*Glossary* Section" for the definition of a *Grandfathered Plan*).

Vasectomies are only covered when the attending Physician can provide documentation of medical necessity. Pre- Authorization by FHCP is required.

Note: Reversals of Tubal Ligations and/or Vasectomies are NOT covered. See the "*Exclusions and Limitations*" Section.

Woman's Health – Family Planning

The following provisions (#'s 1 – 4) apply to "*Grandfathered Plans*" ONLY. (See the "*Glossary*" Section for the definition of a Grandfathered Plan). When receiving these services, the Member will be responsible for the applicable copayment, coinsurance and/or deductible.

1. **Contraceptive Medications (Oral)** are covered through FHCP when prescribed and the Member has FHCP Prescription Drug Coverage as part of his/her Employer Group Benefit Plan. Oral contraceptive medications must be listed on FHCP's *"Prescription Drug Formulary."*
2. **Contraceptive Medications;** Professionally administered Implanted or Injectable (e.g., Depo Provera) contraceptive medications must be listed on *FHCP's "Prescription Drug Formulary."*

3. **Intrauterine Devices:** ONLY intra-uterine devices (IUDs) when administered by a contracted Provider are covered.

   Diaphragms, Sponges and other self- administered devices are excluded. See the "*Exclusions and Limitations*" *Section***.**

4. **Tubal Ligations are only covered when** the attending Physician can provide documentation of medical necessity. Pre-Authorization by FHCP is required.

Note: Reversals of Tubal Ligations and/or Vasectomies are NOT covered. See the "Exclusions and Limitations" Section.

Woman's Preventive Health

The following services *(#'s 1 - 4)* may be available to Members in all *new plans* and *"Non-Grandfathered Plans".* Most of these services, unless otherwise indicated, are at no Out-of-Pocket cost to the Member. (See "*Glossary"* Section for a definition of a "*Non-Grandfathered Plan")*.

Any related services or alternative services not specifically listed below, or described in a special "Note" below, are subject to other coverage provisions of this Certificate of Coverage including cost-sharing and/or "*Exclusions and Limitations."*

It is important to understand that your coverage for the Preventive Services listed below is based on your Group Plan's "*Effective Date*." If there are additions or changes to these recommendations or guidelines after your "*Effective Date;"* your coverage will not change until your Group Plan's next "*Anniversary / Renewal Date"* which may be up to one year after the recommendations or guidelines went into effect:

1. **Annual Well Woman's Examination**. This examination will include the following services:
   a. **Counseling and Screening** for Human Immune-Deficiency Virus (HIV);
   b. **Counseling and Screening** for Human Papilloma Virus (HPV);
   c. **Counseling** for Sexually Transmitted Infections;
   d. **Counseling and Screening** for Interpersonal and Domestic Violence; and
   e. **Urinary Incontinence Screening**
2. **Well Woman's Examination for Pregnant Women**: This examination will include the following services:
   a. Alcohol Misuse;
   b. Anemia Screening;
   c. Bacteriuria Screening;
   d. Breastfeeding Counseling;
   e. Chlamydial Infection Screening;
   f. Folic Acid Supplementation;
   g. Gestational Diabetes;

h. Gonorrhea Screening;

i. Hepatitis B Screening;

j. Postpartum Diabetes Screening

k. RH Incompatibility Screening;

l. Syphilis Screening; and

m. Tobacco Use.

3. **Breastfeeding Support, Supplies & Counseling:**

   a. **Lactation support and counseling** will be provided as part of both pre- and post-natal care.

   b. Breast pumps: One manual or basic single or dual electric breast pump, will be provided per delivery. **Must be obtained from an HMO contracted supplier.**

   Note: Also see "*Limitations"* sub-section in the *"Exclusions and Limitations"* Section

4. **Contraceptive Counseling and Methods**: The following services are provided by FHCP. Certain Group sponsored Plans may choose and certify to be exempt from all of the services listed below on the **basis** of sincerely held religious belief. In addition, certain Non-Profit Organizations, For-Profit Organizations that are not publicly traded and Small Businesses may choose and certify to be exempt from all of the services listed below based on non-religious moral convictions opposing such services. However, Individual employees of such groups, Individual Plan Subscribers and/or their dependents may still request and receive these services and be responsible for the Usual and Customary Rate (UCR) for that service. The UCR is often referred to as the Out-of-Pocket cost for patients.

   a. **Counseling:** For all women with reproductive capacity;

   b. **Barrier Devices:** FDA approved diaphragms with a Physician's prescription presented at an FHCP pharmacy;

   c. **Implantable Devices**: FHCP's coverage of IUDs is formulary based. Prior authorization from FHCP is required for coverage of IUDs that are not included in the formulary. Service(s) related to the insertion or removal of the IUD is covered in full;

   d. **Oral Contraceptives**: Are covered by FHCP when prescribed by a Physician and the Member has FHCP Prescription Drug Coverage as part of their Group Plan. Oral Contraceptive medications must be generic only and listed on FHCP's *"Prescription Drug Formulary."*

      Note: Prescriptions for brand name oral contraceptives will be required to meet medical necessity and will require Prior Authorization from FHCP.

   e. **Other Methods:** Condoms and the "*Morning after Pill*" approved by the FDA: A prescription is required for these specific types of contraceptives and they are only available at a FHCP Pharmacy***.***

Note: Physician/Professionally administered Implantable and injectable contraceptives (e.g., Depo-Provera) must be listed in the FHCP "*Medical Prescription Drug Formulary*" to be covered at no cost to the Member.

f. **Tubal Ligations:** Prior Authorization is required when performed in a Surgical Facility (*Ambulatory Surgery Center, or Outpatient Hospital Facility*)

Note: Reversal of tubal ligation is excluded under the plan. (See the "*Exclusions and Limitations*" Section.*)*

Section 17: Behavioral, Mental Health, & Substance Dependency Services

The following Services may be covered when provided for a Member by a Contracted Provider in the treatment and diagnosis included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as updated and revised. The DSM is the standard classification of mental disorders used by mental health professionals in the United States.

Some of these services require Prior Authorization by FHCP. All services are subject to the copayment, coinsurance, and/or deductible, as applicable. (See your "*Summary of Benefits and Coverage"* and *"Schedule of Benefits."*)

Note: For Members with a Point-of-Service or Triple Option Plan: Several of these services are subject to Pre-Certification. Please refer to your Point of Service or Triple Option Plan *"Summary of Benefits and Coverage"* and *"Schedule of Benefits."* When you utilize a Contracted Provider your claim(s) will be processed at the Maximum, HMO Benefit Level minus applicable HMO copayment, coinsurance, and/or deductible. **Utilization of Non-Contracted Providers, except for emergency or urgently needed care, will result in a higher financial responsibility on your part; higher copayment, coinsurance and/or deductible, plus any applicable balance billing.** (See your "*Summary of Benefits and Coverage"* and *"Schedule of Benefits.")*

Behavioral & Mental Health Services

Inpatient Services

For crisis intervention, evaluation, diagnosis, or treatment of a Mental and Nervous Disorder or Detoxification may be covered if service is received in the FHCP Service Area at a Contracted Hospital or appropriate Contracted Facility and has been Pre-Authorized in accordance with criteria established by FHCP. These services must be provided by a licensed contracted Physician, Psychologist, or Mental Health Professional while confined in a Contracted Hospital or a Psychiatric Facility for the treatment.

Inpatient coverage is to include:

1. Room and board in a semi-private room, unless the patient must be isolated from others for documented clinical reasons;
2. Drugs and medicines administered while an inpatient;
3. Intravenous solutions;
4. Therapy both individual and group sessions when provided by a licensed, Physician, Psychiatrist, Psychologist, or Mental Health Professional; and
5. Other Medically Necessary Services

Partial Hospitalization

For Mental Health Services is a structured, short-term treatment program that offers nursing care and active participation in a treatment program that is operable a minimum of 6 hours per day, 5 days per week. **Partial Hospitalization is a Covered Service only when it is provided in lieu of inpatient hospitalization and when Prior authorization is obtained from FHCP.**

Note*:* To be covered: Partial Hospitalization Services must be provided under the direction of a Physician who is a Contracted Provider; Outpatient treatment of a Mental and Nervous Disorder, including diagnostic evaluation and psychiatric treatment Individual therapy and group therapy must be provided by a licensed Physician, Psychiatrist, Psychologist, or Mental Health Professional; **and Prior Authorization has been requested and coverage is authorized in accordance with criteria established by FHCP.**

Residential Services for Behavioral and Mental Health Care

Services must be provided in an appropriately licensed Residential Treatment Center that is contracted with FHCP and operated as a sub-acute or intermediate care facility. Such facilities must provide treatment services 24 hours per day, 7 days per week. A minimum of one Physician visit per week in the facility setting is required to manage and update the plan of care. Residential Services must be authorized in accordance with criteria established by FHCP. For this benefit to be a Covered Service, FHCP Prior Authorization must be obtained. The number of benefit days is limited. (*See your "Summary of Benefits and Coverage" and "Schedule of Benefits"* for Skilled Nursing, Residential & Rehabilitation Facilities limitations.)

Note: Residential services that provide care where the primary purpose is to attend to the Member's activities of daily living which do not include or require the continuing attendance of trained medical or licensed mental health professionals are not covered and are at the Member's own expense. Examples of this include but are not limited to: assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, or the supervision / administration of *medication which can be self*-administered by the Member.

Outpatient Treatment

Including the diagnostic evaluation and psychiatric treatment, individual therapy, and group therapy will be covered to both confirm and treat a diagnosis of behavioral / mental health disorders in accordance with nationally recognized guidelines including but not limited to: National Alliance on Mental illness (NAMI); Milliman Care Guidelines; and the National Institute of Mental Health (NIMH). Treatment must be provided by a licensed, Contracted Physician, Psychiatrist, Psychologist, or Mental Health Professional.

Telehealth *(Telemedicine)* Services:

See the *"Limitations"* sub-section of the *"Exclusions and Limitations"* Section.

Substance Dependency Treatment Services

Detoxification

Includes services that are necessary for the removal of toxic substances from the blood and outpatient follow-up care rendered by a licensed professional. Inpatient and outpatient Detoxification coverage must be Pre-Authorized in accordance with criteria established by FHCP for this benefit to be a Covered Service.

Inpatient Hospital Services

For substance dependency, evaluation, diagnosis or treatment are covered if the service is received in the Service Area at a Contracted Inpatient Facility and has been Pre-Authorized in accordance with criteria established by FHCP which is based upon nationally recognized standards of care. These services must be provided by a licensed, Contracted Physician, Psychiatrist, Psychologist or Mental Health Professional while the Member is confined in a Contracted Hospital or Psychiatric Facility.

Inpatient coverage is to include:

1. Room and board in a semi-private room, unless the patient must be isolated from others for documented clinical reasons;
2. Drugs and medicines administered while an inpatient;
3. Intravenous solutions;
4. Therapy both individual and group sessions when provided by a licensed, Physician, Psychiatrist, Psychologist, or Mental Health Professional; and
5. Other Medically Necessary Services to include diagnostic, physical, and respiratory therapy services.

Partial Hospitalization for Substance Dependency

For the treatment of Substance Dependency is a structured, short-term treatment that offers nursing care and active participation in a program that is operated a minimum of 6 hours per day, 5 days per week. **Partial Hospitalization is a Covered Service when it is provided in lieu of inpatient hospitalization and when Prior Authorization is obtained from FHCP.**

Note: To be covered: Partial Hospitalization Services must be provided under the direction of a Physician who is a Contracted Provider; Outpatient treatment of Substance Dependency Individual therapy and group therapy must be provided by a licensed

Psychiatrist, Psychologist, or Mental Health Professional; and Prior Authorization has been requested and coverage is authorized in accordance with criteria established by FHCP.

Residential Substance Dependency Rehabilitation Services

Residential Services must be provided in an appropriately licensed Residential / Dependency Rehabilitation Treatment Center that is contracted with FHCP and designed as a sub-acute or intermediate care facility. Care and treatment are available 24 hours per day, 7 days per week, and requires a skilled level of care by licensed Physicians, Nurses and Mental Health Professionals. In order to be a Covered Service, Prior authorization by FHCP must be obtained. The number of benefit days is limited.

(*See your "Summary of Benefits and Coverage" and "Schedule of Benefits"* for Skilled Nursing, Residential & Rehabilitation Facilities limitations.)

Outpatient Services for Substance Dependency

Outpatient services for the evaluation, care and treatment of Substance Dependency will be provided in accordance with nationally recognized guidelines including but not limited to: The Substance Abuse and Mental Health Services Administration (SAMSHA); the American Society of Addiction Medicine (ASAM); Milliman Care Guidelines; National Institute on Drug Abuse (NIDA; and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Such services include treatment, individual and group, and must be provided by a licensed, Contracted Physician, Psychiatrist, Psychologist, or Mental Health Professional. Prior Authorization by FHCP must be obtained.

Services provided through an "Intensive Outpatient Program" (IOP) for people with substance use disorders or other mental / behavioral health disorders who do not require medical detoxification or 24-hour supervision may also be available as an alternative to inpatient and residential treatment. These types designed to establish psychosocial supports and facilitate relapse management and coping strategies. These services can be provided in both group and/or individual setting and are designed to establish support mechanisms, help with relapse management and provide coping strategies. Prior Authorization by FHCP must be obtained in order for this type of service to be covered.

Note: Non-Medical Ancillary Services such as vocational rehabilitation or employment counseling, half-way houses, group homes, private residence and community-based services such as Alcoholics Anonymous may be available to the Member, however; **Services of this type are solely at the Member's expense.** The Member acknowledges that FHCP does not have any contractual or other formal arrangements with the providers of such Services.

Section 18: Exclusions & Limitations

Exclusions

THE FOLLOWING ARE EXCLUDED FROM COVERAGE:

Any Services not specifically listed in the *"Covered Medical Services"* Section or in any Rider, or Endorsement attached hereto, unless such expenses are specifically required to be covered by applicable law.

If the Member does not follow FHCP's "*Coverage Access Rules*" any services provided to, or received by, the Member are not covered. For further information, please refer to the "*Coverage Access Rules"* Section.

Any Service which, in the opinion of FHCP was, or is, not Medically Necessary. The ordering of a service by a health care provider, including without limitation, a health care provider who is a Contracted Provider, other than as authorized by FHCP, does not in itself make such service Medically Necessary or a Covered Service.

Abortion including any services or supplies related to an elective *(Not Medically Necessary)* abortion except for services related to spontaneous abortion *(Miscarriage)* or an abortion performed for Medically Necessary reasons when authorized by FHCP.

Ambulance Services other than those specifically provided for in the "*Covered Medical Services*" Section.

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/or modifications)* for the treatment of severe diabetic foot disease.

Autopsy or postmortem examination Services, unless specifically requested by FHCP.

Complementary and Alternative Healing Methods including, but not limited to, self-care or self-help training; Massage Therapy, Bio-feed Back, Homeopathic Medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; prayer and mental healing; massage therapy and manual healing methods such

as the Alexander Technique, Aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, Hypnosis and Hypnotic therapy, Polarity therapy, Reichian Therapy, Reflexology, Rolfing, Shiatsu, Swedish Massage, traditional Chinese Massage, Trager Therapy, Trigger-point Myotherapy, and Biofield Therapeutics; Reiki, SHEN Therapy, and therapeutic touch; bio-electromagnetic applications in medicine; and herbal therapies.

Complications of Non-Covered Services, including the diagnosis or treatment of any Condition which arises as a complication of a non-Covered Service *(e.g., services or supplies to treat a complication of cosmetic surgery are not covered).*

Contraceptive Devices or Appliances that are self-administered devices, supplies, and/or available over the counter (OTC) without a prescription, unless otherwise listed in the "*Covered Medical Services"* Section.

Note: Those devices or appliances listed in the "*Covered Medical Services"* Section require a prescription and are only available at an FHCP Pharmacy.

Copayments, Coinsurance, and/or Deductible if applicable (See your *"Summary of Benefits and Coverage"* and *"Schedule of Benefits"*), whether or not the cost share amount has been waived by the provider. (*This provision also includes any applicable Balance Billing.)*

Cosmetic Services including any Service to improve the appearance or self-perception of an individual, including without limitation: cosmetic surgery; cosmetic procedures during or related to sexual transition, reassignment, or modification; body sculpting; and procedures or supplies to correct hair loss or skin wrinkling *(e.g., Minoxidil, Rogaine, Retin-A).* The fact that a Member may suffer psychological consequences or socially avoidant behavior as a result of an Injury or Illness (*with the exception of a positive diagnosis of breast cancer*) does not classify a cosmetic surgery or other cosmetic related procedure(s) as a covered benefit.

Costs related to failure to keep a scheduled appointment *(no show charge)*, or costs incurred for completion of any Member requested forms and /or medical information such as Member requests for copies of medical records.

Cranial Appliances or Devices: See *"Limitations"* sub-section.

Custodial Care for personal needs and any Service of a custodial nature including without limitation: Services or supplies primarily to assist the Member in the activities of daily living; rest homes; home companions or sitters; home mothers; domestic maid services; and respite care.

Dental Care or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, dental braces, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment, intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays. Procedures and/or services for preparation of the mouth or jaw in the providing of Dental Care, this includes but is not limited to, for the purpose of restoration of sound teeth such as dentures, bridges, crowns, or implants.

This exclusion does not apply to Accidental Dental Care, Child Cleft Lip and Cleft Palate Treatment Services or those Health Risk Assessment Services for children. (See the *"Covered Medical Services"* Section.)

Drugs prescribed for uses other than the United States Food and Drug Administration (FDA)-approved label indications.

This exclusion does not apply to any drug that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer-reviewed full-length articles in respected national professional medical journals. This exclusion also does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of the Member's particular cancer in a Standard Reference Compendium or is recommended for treatment of the Member's particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

Note: See the "*Covered Medical Services*" Section, your "*Schedule of Benefits*," "*Summary of Benefits and Coverage*," and the FHCP *"Medical Pharmacy Formulary*."

Durable Medical Equipment which is for patient convenience and/or comfort or not specifically described in the *"Covered Medical Services"* Section. This exclusion includes, but is not limited to, modifications to motor vehicles and/or homes such as wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and massage equipment, electric scooters *(Unless specific criteria has been meet and the device is used for activities of daily living within the home environment)*, hearing aids, dental braces, dentures, dental implants, air conditioners, humidifiers, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails, heat appliances and

dehumidifiers. Also excluded is coverage for repair or replacement of covered Durable Medical Equipment unless Pre-Authorized by FHCP.

Erectile Dysfunction services, supplies, devices, or medications regardless of etiology of the diagnosis.

Experimental or Investigational Services except as otherwise covered under the Bone Marrow Transplant provision of the *"Transplant Services"* in the "*Covered Medical Services"* Section.

Exercise Devices or Training necessary to participate in sports, *(e.g., custom-made knee braces).*

Family Planning Services other than those Services specifically described in the "*Covered Medical Services"* Section as applicable to your type of plan (*Grandfathered or Non-Grandfathered* definitions appear in the *"Glossary"* Section*).*

Foot Care (Routine) including any service or supply in connection with foot care in the absence of disease. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, corns, or calluses, unless determined by FHCP to be Medically Necessary.

Gender Dysphoria / Sexual Reassignment / Modification including but not limited to any service or supply related to such treatment, including psychiatric services **are excluded for all Members enrolled in a Grandfathered Plan.** (See *"Grandfathered Plan"* in the *"Glossary"* Section.)

Enrollees in Non-Grandfathered Plans See *"Gender Dysphoria"* in the *"Limitations"* sub-section and the *"Covered Medical Services"* Section.

Habilitation Services, regardless of the type of service, when provided for the purpose of attaining or maintaining a function NOT lost due to accident, illness, or surgery, are excluded.

For services related to Autism Spectrum Disorders Pervasive Developmental Disorder *(not otherwise specified*); Childhood Disintegrative Disorder; and Down's Syndrome see the *"Covered Medical Services"* Section and *"Limitations"* sub-section.

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

Immunizations and Physical Examinations when required for travel or insurance except when such examinations are within the scope of, and coincide with, the periodic health assessment examination and/or State law requirements; or except when the immunization(s) is necessary in the course of other medical treatments of an illness, injury, or is listed as a recommend preventive health service by the *USPSTF (*See *"Glossary"* Section*)*.

Infertility Treatment services and associated expenses regarding the confirmatory testing, diagnosis of and treatments for infertility, including any prescription medications for the treatment of infertility; In Vitro Fertilization (IVF); Sperm Count on the Male; Collection of sperm for the purpose of cryopreservation; Gamete Intra-fallopian Transfer (GIFT) procedures; Zygote Intra-fallopian Transfer (ZIFT) procedures; embryo transport; surrogate parenting; donor semen and related costs including collection, preparation, and storage; and Artificial reproductive treatment done for genetic or eugenic purposes.

Maternity Services rendered to a Member who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or Arrangement. This exclusion applies to all expenses for prenatal, intra-partum, and post-partum maternity/obstetrical care, and Health Care Services rendered to the Member acting as a Gestational Surrogate.

Mental Health Services which are

1. Rendered in connection with a condition not classified in the most recently published version of the Diagnostic and Statistical Manual of Mental Disorders *(DSM*) of the American Psychiatric Association;
2. For psychological testing associated with the evaluation and diagnoses of learning disabilities or for Intellectual Disability.
3. For marriage counseling;
4. For pre-marital counseling;
5. Court ordered care or testing, or required as a condition of parole or probation;
6. Testing for aptitude, ability, intelligence or interest;
7. Testing and evaluation for the purpose of maintaining employment;
8. Cognitive remediation;
9. Inpatient confinements that are primarily intended as a change of environment; or
10. Mental Health Services received in a residential treatment facility unless authorized by FHCP prior to admission to the facility.

Military Service-Related Medical Care received at military or government facilities.

Non-Medical Ancillary Services such as vocational rehabilitation or employment counseling, half-way houses, group homes, private residence and community-based services such as Alcoholics Anonymous may be available to the Member, **Services of this type are solely at the Member's expense.** The Member acknowledges that FHCP does not have any contractual or other formal arrangements with the providers of such Services.

Non-Prescription Drugs or Products except insulin, including any non-Prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, health foods, single use items such as bandages, dressings, masks, alcohol wipes, and support garments unless specifically listed in the *"Covered Medical Services" and the "Prescription Drug Coverage"* Sections.

Oral Appliances for Sleep Apnea that are strictly for the Member's convenience and/or comfort purposes including those sleep aids/appliances that are dispensed Over the counter (OTC) **and** not specifically identified as covered in the *Prosthetic and Medical Brace Devices"* sub-section of the "*Covered Medical Services*" Section for a confirmed medical diagnosis.

Oral Surgery for any reason, including oral surgery the primary purpose of which is to improve the appearance or self-perception of an individual, except as provided in the *"Covered Medical Services*" Section.

Orthomolecular Therapy including nutrients, vitamins, and food supplements.

Orthotics See *"Arch Supports"* in this Section.

Personal Comfort, Hygiene or Convenience Items, and Services deemed to be not Medically Necessary and not directly related to the care of the Member, including, but not limited to, beauty and barber services, clothing, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than Medically Necessary ambulance services or other transportation services that are specifically provided for in the "*Covered Medical Services"* Section, motel/hotel accommodations, air conditioners, humidifiers, or physical fitness equipment.

Private Duty Nursing Care is not covered and is at the Member's own expense.

Rehabilitation Services see both the "*Limitations"* sub-section and the "*Covered Medical Services."*

Residential Services that provide care where the primary purpose is the Member's activities of daily living which do not require the continued attendance of trained medical or licensed professionals are not covered and are at the Member's own expense. Examples of this include but are not limited to: assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, or the supervision/administration of medication which can be self-administered by the Member.

Reversal of Voluntary surgically induced Sterility, or Sexual Reassignment / Modification, including without limitation, the reversals of Tubal Ligations and Vasectomies.

Services or Supplies that are:

1. Determined to be not Medically Necessary;
2. Not specifically listed in the "*Covered Medical Services"* Section unless such services are specifically required to be covered by State or Federal law. FHCP will provide coverage on a primary or secondary basis as required by applicable COB state or Federal laws;
3. Court ordered care or treatment, unless otherwise covered;
4. For the treatment of a Condition resulting directly or indirectly from:
    a. War or an act of war, whether declared or not. *(This does not include civilian victims of war or victims of acts of Terrorism);*
    b. Participation in any act which would constitute a riot, rebellion, terrorism, or a crime punishable as a felony;
    c. Engaging in an illegal occupation; or
    d. Services in the armed forces.
5. Received prior to a Member's Effective Date or received on or after the date a Member's Coverage terminates under the Group Plan, unless coverage is extended in accordance with the "*Extension of Benefits"* sub-section;
6. Provided by a Physician or other health care provider related to the Member by blood or marriage;
7. Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group unless included in the terms of the Group's Contract with FHCP;
8. For treatment of non-medical conditions related to hyperkinetic syndromes, learning disabilities, Intellectual Disability, or inpatient confinement for environmental change;
9. Supplied at no charge;
10. For elective care, routine care, or any care other than Medically Necessary emergency care, required by a Member while outside of the Service Area; or

11. For normal pregnancy and delivery outside the Service Area, unless the need for such services was not, and reasonably could not have been, anticipated before leaving the Service Area or such services were authorized by FHCP before they were rendered.
12. That are prohibited to be provided by State of Florida law or the State of Florida Department of Health.

Skilled Nursing Facility Services not provided in lieu of hospitalization.

Smoking Cessation products or services designed to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products *(e.g., gum, transdermal patches)* **unless it is prescribed by a Physician and is one of the USPSTF Preventive Medications and Supplements listed in the FHCP *"Prescription Drug Formulary."*** *(*See the *"Prescription Drug Coverage"* Section.)

Sports-Related Devices 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.

Tobacco or tobacco related products.

Training and Educational Programs; including programs primarily for vocational rehabilitation.

Transplantation or Implantation Services, including the transplant or implant, other than those specifically listed in the "*Covered Medical"* Section. This exclusion includes:

1. Any Service in connection with the implant of an artificial organ, including the implant of the artificial organ;
2. Any organ which is sold rather than donated to the Member;
3. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in Chapter 59B-12.001 and as also governed under 59C-1.044 of the *Florida Administrative Code* or covered by Medicare pursuant to a national coverage decision made by the Health Care Financing Administration as evidenced in the most recently published Medicare Coverage Issues Manual; and
4. Any Service in connection with identification of a donor from a local, state or national listing.

Transportation, travel, lodging or vacation expenses including reimbursement of such expenses even if prescribed or ordered by a provider or related to medical service(s), treatment(s), or procedure(s) that have been Pre-Authorized by FHCP.

Vision Care except for Vision Health Risk Assessments for children, routine vision care is excluded including

1. The purchase, examination, or fitting of eyeglasses or contact lenses, except **only the first** pair of eyeglasses or contact lenses following cataract surgery; limited to single vision contacts or a basic eyeglass frame with single vision *(near or far)* lenses; or conventional "flat top" bifocal lenses.

   Note: Special lenses including but not limited to photo-chromatic, progressive, scratch resistant, tinted, and lightweight as well as sunglasses will not be covered. Frames are limited to a basic frame; designer or specialty frames (e.g., sports goggles) will not be covered. (Also see "prosthetics" in the "Covered Medical**" Section)**

2. Any surgery for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error *(e.g., radial keratotomy, myopic keratomileusis*); and
3. Training or orthoptics, including eye exercises.

Volunteer Services or services which would normally be provided free of charge to a Member including Services which would normally be provided free of charge in a Hospice program; Services of a person who ordinarily resides in the home of the terminally ill Member, or is a member of the Member's family, or of the Member's spouse's family; or any Service not provided through the Hospice program approved by FHCP.

Weight Control Services See the *"Limitations"* Sub-section.

Wigs regardless of any underlying medical diagnosis or treatment.

Work Related Condition Services to the extent the Member is covered or required to be covered by Workers' Compensation law. Any Service or supply to diagnose or treat any Condition resulting from or in connection with a Member's job or employment will not be covered under the Group Plan, except for Medically Necessary Services *(not otherwise excluded)* for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual.

Limitations

THE RIGHTS OF MEMBERS AND OBLIGATIONS OF FHCP HEREUNDER ARE SUBJECT TO THE LIMITATIONS SET FORTH ON THE *"SUMMARY OF BENEFITS AND COVERAGE," "SCHEDULE OF BENEFITS,"* AND THE FOLLOWING LIMITATIONS.

Autism Spectrum Disorders; Pervasive Developmental Disorder *(not otherwise specified*); Childhood Disintegrative Disorder; and Down's Syndrome treatment is limited to services specifically identified in the "*Autism Spectrum Disorder"* in the *"Covered Medical Services"* Section. Any Habilitative or related Service(s) rendered for any diagnosis other than specifically classified as Autism Spectrum Disorder as defined in the "*Glossary"* Section will not be covered.

Breast Pumps (*Non-Grandfathered Plans only***):** Only one manual or basic single or dual electric breast pump as listed in the "*Covered Medical Services"* Section are a covered benefit under the Plan. All other types of specialized breast pumps are excluded.

Clinical Trials: Both the Member and the Clinical Trial must meet specific criteria (See the "*Clinical Trials"* in the *"Covered Medical Services"* Section). Available benefits are limited to Routine Services ONLY (*Those items and services that FHCP would cover under the Group Plan if the Member were not enrolled in a Clinical Trial*). Items, devices, and services that are investigational or items and services solely for the purpose of data collection and not for direct clinical management or inconsistent with established standards of care for the Member's diagnosis are not covered.

Cranial Appliances or Devices which purpose is to 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).*

Cranial Appliances or Devices may be covered under the health plan when used as an alternative to an internal fixation device as a result of surgery for craniosynotosis or for a diagnosis of and, management of, positional plagiocephaly in children up to 18 months. To be covered specific medical necessity criteria must be met and you must have received Prior Authorization from the Plan.

Gender Dysphoria / Sexual Reassignment / Modification:

The following Limitations and Exclusions apply ONLY to Members in all new *plans and "Non-Grandfathered Plans" (any Plan written by FHCP on or after March 23, 2010)*. (See "*Glossary*" Section for a definition of a "*Non-Grandfathered Plan*").

Exclusions

The following services are directly excluded under the Plan:

1. Cosmetic Procedures **and** any complications related to such procedures including the following:
   a) Abdominoplasty;
   b) Blepharoplasty;
   c) Body Contouring such as Lipoplasty, Liposuction, Cyro-Sculpting, and "CoolSculpting;"
   d) Breast Modifications including: Mastectomy; Enlargement / Augmentation; Mammoplasty; Fat Injections; and Breast Implants;
   e) Brow Lift;
   f) Calf Implants;
   g) Cheek, Chin, and Nose implants, injections of fillers, or neurotoxins. (*e.g. Botox*);
   h) Face Lift, Forehead Lift, Neck / Jowl Tightening, Facial Bone Remodeling for facial feminizations, Facial Hair Removal;
   i) Hair Transplantation;
   j) Laser or Electrolysis Hair Removal;
   k) Lip Augmentation or Reduction;
   l) Mastopexy;
   m) Pectoral Implants for chest masculinization;
   n) Rhinoplasty;
   o) Skin Resurfacing;
   p) Thyroid Cartilage Reduction / Reduction Thyroid Chondroplasty;
   q) Trachea Shaving *(Chonrolaryngoplasty Reduction of the "Adams Apple")*;
   r) Voice Modification Surgery; and
   s) Voice Lessons and Voice Therapy.
2. Reversals of any sexual reassignment procedure(s).

Limitations:

The following services may be covered ONLY when pre-authorized by FHCP and as listed in the Covered Services Section:

1. Hormone Therapy;
2. Psychological / Behavioral Health Therapy; and
3. Sexual Re-Assignment Procedure(s). (See the "*Covered Medical Services*" Section for a complete list of procedures that may be covered.)

IMPORTANT NOTE: Members with a Point-of-Service (POS) or Triple Option Plan: These services will ONLY be covered when Prior Authorization by FHCP has been obtained.

Penile Prosthesis

Exclusions:

Penile prosthesis and/or surgery to insert or remove a penile prosthesis for a diagnosis of erectile dysfunction is excluded.

Limitations:

Penile Prosthesis and/or surgery to insert or remove a penile prosthesis may be covered for a Member with a history of prostate cancer or as listed in the *"Covered Medical Services*" Section. (See "*Gender Dysphoria / Sexual Reassignment / Modification.).*

Prescription Drugs dispensed to, or purchased by, a Member from a pharmacy. **This exclusion does not apply to drugs dispensed to a Member when:**

1. The Member has a Group Plan that includes an FHCP Prescription Drug Benefit and the prescription drugs were dispensed in accordance with that Plan's provisions for access, copayment, coinsurance and/or deductible. (See *your "Summary of Benefits and Coverage," "Schedule of Benefits,"* the *"Prescription Drug Coverage"* Section, and applicable *"Prescription Drug Formulary"*);
2. The Member is an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility;
3. The Member is in the outpatient department of a Hospital;
4. Dispensed to the Member's Physician for administration to the Member in the Physician's office and prior coverage authorization has been obtained *(if required). (*See "*Medical Pharmacy*" in the "*Covered Medical Services*" Section.); or
5. The Member is receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills FHCP for such drugs, including Self-Administered Prescription Drugs that are rendered in connection with a nursing visit.

Rehabilitation Services, including physical, speech, occupational, behavioral, substance dependency, and other rehabilitation therapy, except as described in the "*Covered Medical Services"* Section and the "*Behavioral, Mental Health & Substance Dependency"* Section. **This exclusion includes:**

1. Services or supplies provided to a Member as an inpatient in any Hospital, Skilled Nursing Facility, institution, or other facility, where the admission is primarily to provide rehabilitative Services **and Prior Authorization from FHCP was not obtained;**
2. Services or supplies that **exceed the Rehabilitation Plan that was approved by FHCP** and/or **exceeds any applicable day and/or visit limitations under the Plan.**

   (See your "*Summary of Benefits and Coverage"* and *"Schedule of Benefits"*); or
3. **Services that maintain rather than improve** a level of physical, behavioral, mental health function, or where it has been determined that the services are not Medically Necessary and will not result in significant improvement in the Member's Condition.

Telehealth *(Telemedicine)* Services are limited to board-certified Physicians and Mental/Behavioral Health Providers. To be covered, these services must be rendered by a Telehealth provider contracted with FHCP specifically for such services.

IMPORTANT NOTE: Members with a Point-of-Service (POS) or Triple Option Plan: Telehealth Services will only be covered when you are connected to a Board-Certified Physician or Mental / Behavioral Health Provider contracted with FHCP specifically for such services.

If you utilize an Out-of-Network, Non-contracted Telehealth / Telemedicine Service the service(s) will **NOT** be covered under your POS or Triple Option Plan.

Weight Control Services

Exclusions

The following weight loss services are directly excluded under the Plan: Any service to lose, gain or maintain weight.

This exclusion includes but is not limited to: Appetite suppressants or stimulants including those available over the counter **or** prescribed by a health care provider; Dietary regimens or commercial programs such as Golo, Jenny Craig, Noom, Nutrisystems and Weight Watchers (WW), Food or food supplements; Exercise programs; Exercise or other equipment; Weight loss procedures including: Intestinal bypass, gastric balloons, jejunal bypass, gastric shunts, lap-band, and procedures designed to restrict the Member's ability to assimilate food (e.*g. jaw wiring*). (*Also see the "Limitations" below for specific procedures that may be covered*.)

Limitations

The following Weight Control Services MAY BE COVERED:

Medical Weight Management Programs **MAY BE COVERED** when all the following are met: *(*See definition of *"Medical Weight Management Program"* in the *"Glossary"* Section.)

1. The weight management service(s) **must be rendered by an HMO provider that is specifically contracted to provide these types of services to our Members;**
2. The Member must meet medical necessity criteria. Factors for medical necessity include but are not limited to: A BMI of 30 or greater with other risk factors such as high cholesterol, hypertension, diabetes, and sleep apnea. The Member must be referred to a FHCP contracted Weight Management Program by the Member's physician (*PCP or Specialist* (*e.g., Endocrinologist*); and
3. Gym Membership is **only available to enrollees in employer group plans that include a "*Gym Access*" rider**. The Gym **must** be a provider that is specifically contracted to provide these types of services to our Members.

The following bariatric surgery procedures: Roux-en-y; Gastric bypass; and Vertical sleeve gastrectomy **MAY BE COVERED.**

These services are only covered when all the following criteria are met:

1. The weight reduction program and bariatric surgery services are each pre-authorized by FHCP;
2. The Member must meet medical necessity criteria. Factors for medical necessity include but are not limited to: A BMI of 35 or greater with other risk factors such as high cholesterol, hypertension, diabetes, and sleep apnea. The Member must be referred to a FHCP contracted program by the Member's physician (PCP or appropriate Specialist (*e.g., Endocrinologist*);
3. The service(s) **must** be rendered by an HMO provider that is specifically contracted to provide these types of services to our Members;
4. The Member must complete all program requirements established by FHCP and the HMO contracted provider **prior** to having one of the covered bariatric procedures listed in this paragraph;
5. The Member must be continuously enrolled in FHCP for 12 months prior to a covered bariatric procedure; and
6. The Member must be planning to remain enrolled in FHCP for at least 12 months after the covered bariatric surgical procedure for medical monitoring purposes.

IMPORTANT NOTE: Members with a Point-of-Service (POS) or Triple Option Plan: These services will ONLY be covered when all of the above listed criteria have been met including Prior Authorization by FHCP; and when rendered by an HMO network provider that is contracted with FHCP to provide these services.

Utilization of any Out-of-Network, Non-contracted Provider(s) for any of the services listed above will NOT be covered under your POS or Triple Option Plan.

Circumstances Beyond the Control of FHCP

To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within the control of FHCP, results in facilities, personnel, or financial resources of FHCP being unable to arrange for provision of the Covered Services, FHCP shall have no liability or obligation for any delay in the provision of, or any failure by any provider to provide, such Covered Services, except that FHCP shall make a good faith effort to arrange such Services, taking into account the impact of the event. For the purposes of this paragraph, an event is not within the control of FHCP if FHCP cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

Section 19: Prescription Drug Coverage

Introduction

Medications are an important part of your health care benefit. Physicians prescribe medications to patients to treat certain conditions or to prevent illness. Medication effectiveness and safety are important elements of your Prescription Drug Coverage.

What Is Covered

Medications available to you through your FHCP Prescription Drug Coverage are based on a prescription drug Formulary. A *"Prescription Drug Formulary"* is a list of drugs covered under the Group's Prescription Drug Plan. The drugs that appear in the *"Prescription Drug Formulary*" are reviewed annually by our "Pharmacy and Therapeutics Committee" consisting of specialty physicians, primary care physicians and pharmacists who evaluate the efficacy, safety and cost effectiveness of medications. They approve the *"Prescription Drug Formulary."*

The "*Prescription Drug Formulary"* includes both generic and brand name drugs. The drugs that are listed in the *"Prescription Drug Formulary"* are assigned to a Tier. There are 7 Drug Tiers in the FHCP "*Prescription Drug Formulary*":

Tier 1 Preferred Generic;

Tier 2 Non-Preferred Generic;

Tier 3 Preferred Brand;

Tier 4 Non-Preferred Brand;

Tier 5 Preferred Specialty;

Tier 6 Non-Preferred Specialty; and

Tier 7 United States Preventive Services Task Force (USPSTF) Preventive Medications & Supplements.

NOTE: Tier 7 applies to Non-Grandfathered Plans ONLY. (See "*Glossary*" Section for definition of a Non-Grandfathered Plan.) Select OTC Drugs listed in the Prescription Drug Formulary may be covered when you get a prescription for the OTC Drug from your physician. *(*See the *"Preventive Medications & Supplements"* sub-section.)

Out-of-Pocket Cost

The Member's Out-of-Pocket-cost for a specific drug will depend upon the **"**Tier" that drug is assigned. Please see your "*Summary of Benefits and Coverage"* and *"Schedule of Benefits"* for the Out-of-Pocket cost *(Deductible, copayment and/or coinsurance)* associated with each of these drug "Tiers."

The following drug related costs **MAY NOT** apply to your plan's Deductible and/or Maximum Out-of-Pocket:

1. Cost for non-covered prescription drugs or supplies; or
2. Drug Cost-sharing assistance through manufacturer discount plans, coupons, or cost-sharing assistance, and/or third-party foundations

Changes to the Contract Formulary

During a contract year, the FHCP *"Prescription Drug Formulary"* may change. Changes to the *"Prescription Drug Formulary"* may occur as the result of:

1. A brand drug may be removed from the formulary if a less expensive generic medication becomes available. This may include biosimilar drugs when in accordance with state and federal regulations;
2. A drug will be removed from the formulary if the DEA announces its removal from the Market; or
3. FHCP's *"Pharmacy and Therapeutics Committee"* may determine the need to add a new drug to the formulary upon formulary review.

The most current *"Prescription Drug Formulary"* is always available on FHCP's website at www.fhcp.com.

Choice by Physician and Member

In the event the Member's Physician has prescribed a drug that is not on the FHCP *"Prescription Drug Formulary" (Non-Formulary)* and the medication has not been approved for a Prior Authorization or an Exception, the Member will be responsible for the Usual and Customary (U&C) price for that prescription. Usual and customary prices reflect the costs of the drugs to the consumer at the retail level without the use of insurance. The U&C rate is often referred to as the "cash price" for patients.

Compounded Drugs

Compounded drugs will **ONLY** be covered when dispensed from an FHCP Pharmacy.

Non-sterile compound drugs must contain drugs listed on the FHCP "*Prescription Drug Formulary"* and may contain other pharmaceutical excipients or non-prescription products. The compounded drug will be priced according to the highest cost-sharing Tier of all the FHCP formulary drugs utilized in making the compound.

Bulk chemicals are **NOT** covered on the FHCP Prescription Drug Formulary.

Compounds containing Non-Formulary Drugs are **NOT** Covered. The Member will be responsible for the Usual and Customary (*U&C)* price for that prescription.

Sterile compounded drugs that are intended to be used in the eye, for injection, as infusions, include hazardous drugs, or are required to be made in special facilities are NOT covered and will require a Formulary Exception.

Coverage Access Rules - Pharmacy Network

Pharmacy Network: A Preferred Retail pharmacy is an FHCP owned and operated pharmacy. A Non-Preferred Retail Pharmacy is a participating network pharmacy that is listed in FHCP's Pharmacy Directory and is not owned and operated by FHCP. Members must use a Preferred FHCP pharmacy or a Non-Preferred Retail pharmacy to have a prescription filled or the member will have to pay the full cost of the drug (except in certain situations such as emergencies). Mail Order is only available through FHCP Pharmacy Mail Order. Members should log into their member account at www.fhcp.com and click "**Find a Pharmacy**" to locate a Network Provider pharmacy.

The Member's Out-of-Pocket pharmacy cost *(applicable co-pay, coinsurance, and/or deductible)* will depend on which Pharmacy you choose. See your "*Summary of Benefits and Coverage"* and *"Schedule of Benefits"* for the actual cost share amounts. FHCP pharmacies will cost you less.

Members are encouraged to utilize the FHCP Pharmacies. They are a part of our integrated system. Using these pharmacies allows us to better communicate with your entire health care team and keep you safe.

Additional Coverage Access Rules

The following additional rules apply for the Member's prescriptions to be covered under the Group's Prescription Drug Coverage Plan:

1. Drug(s) subject to Prior Authorization or Step Therapy requirements are **only** available at FHCP Pharmacies unless otherwise specified;
2. Drugs listed in Tier 5 (*Preferred Specialty)* or Tier 6 *(Non-Preferred Specialty)* are only available at FHCP Pharmacies unless otherwise specified;
3. Drug(s) must be prescribed by a Physician or health care professional (*except a Pharmacist*) acting within the scope of his or her license;
4. Drug(s) must be dispensed by a pharmacist;
5. Drug must be dispensed as a generic medication when both a generic and a more expensive drug is available unless otherwise specified;
6. **90% Usage Rule**: Prescription refills for all controlled substance prescription medications will not be covered until at least 90% of the previous prescription has been used by the Member *(based on the dosage schedule prescribed);*

7. **75% Usage Rule:** Prescription refills for all non-controlled substance prescription medications will not be covered until at least 75% of the previous prescription has been used by the Member (*based on the dosage schedule prescribed)*;
8. To obtain at no cost to the Member, USPSTF preventive medications and supplements must be listed in the FHCP "*Prescription Drug Formulary*;" and dispensed ONLY at an FHCP Pharmacy;
9. FHCP will not cover the replacement of lost, damaged, or stolen prescriptions under your Plan benefit;
10. FHCP will not cover more than the maximum supply as set forth in the FHCP *"Prescription Drug Formulary*" and "*Medical Pharmacy Formulary*" and
11. Prescription refills beyond the time limit specified by state and/or federal law are not covered as follows:
    a. A prescription for a controlled substance listed in Schedule III, Schedule IV, or Schedule V may not be filled more than five times within a period of 6 months after the date on which the prescription was renewed by a physician; and
    b. All other prescriptions may not be filled or refilled more than 12 times within a period of 12 months after the day on which a prescription was written.

Note: If you have a Point-of-Service (POS) or Triple Option Plan, in addition to any FHCP Pharmacy, you may also access any Select Non-Preferred Retail walk-in Pharmacy in or outside of FHCP's Service Area. **However, all USPSTF preventive medications and supplements can only be obtained for zero cost at an FHCP Pharmacy.**

USPSTF preventative Medications are available to Members in a Non-Grandfathered Plan ONLY. (See "*Glossary*" Section for definition of a Non-Grandfathered Plan.)

Please see your *"Summary of Benefits and Coverage"* and *"Schedule of Benefits"* for the actual cost share amounts.

Diabetes Medication and Supplies

The following diabetes medication and supplies are covered and subject to the appropriate copayment, coinsurance and/or deductible.

- Insulin;
- Insulin syringes/needles; and
- Insulin pen needles

Note: See the "*Diabetes Treatment Services and Supplies*" sub-section of the "*Covered Medical Services*" Section for additional diabetic supplies covered under you Plan's medical benefit.

Emergency and Urgently needed Care Coverage

Your coverage under your FHCP Prescription Drug Benefit includes prescriptions written during emergency situations. Always present your FHCP membership card to allow the Pharmacy to verify your coverage with FHCP.

Mail Order Pharmacy

FHCP Pharmacy Mail Order is available to all groups with Prescription Drug Coverage. Under this service you can order a 2- or 3-months supply of covered prescription drug(s). This service is recommended for Members that take prescription drugs on a regular basis for a chronic or long-term medical condition.

Medications are delivered to your home or any other address in the United States at no additional charge for standard delivery. FHCP Mail Order can also assist Members who plan to be outside of FHCP's Service Area for an extended period. The Out-of-Pocket cost for a 3 month supply through the mail order pharmacy service can be found in the Member's "*Summary of Benefit Coverage"* and *"Schedule of Benefits"*.

Due to storage issues not all drugs may be available through the Mail Order Pharmacy *(e.g., creams, ointments).*

As a reminder, when outside of our Service Area, any drugs you receive from non-contracted pharmacies will not be covered unless they are related to emergency or urgently needed care services.

Mandatory Generic Rule

If a Brand Name Prescription Drug is requested when there is a Generic Prescription Drug available, the Brand Name Prescription Drug is not covered and the Member will be responsible for the Usual and Customary (U&C) price for that prescription. Usual and Customary prices reflect the costs of the drugs to the consumer at the retail level without the use of insurance. The U&C rate is often referred to as the "*cash price*" for patients.

Medications for Cancer

Certain medications for the treatment of cancer may be listed in the *"Medical Pharmacy Formulary"* and covered under your Group Plan's medical benefits. (See the "*Medical Pharmacy*" sub-section of the *"Covered Medical Services"* Section.)

Medical Pharmacy

Medical pharmacy includes those drugs / medications that require administration by a health care provider. These types of medications are listed in the "*Medical Pharmacy*

Formulary" and are covered under your Group Plan's medical services benefits. (See the "*Covered Medical Services*" Section.)

Preventive Medications & Supplements

In accordance with the United States Preventive Services Task Force (USPSTF) Affordable Care Act A and B recommendations, certain medications, including some over the counter (OTC) medications and supplements **are available at zero cost-sharing to Members in a Non-Grandfathered Plan ONLY provided ALL the following are met:**

1. The Medication / Supplement is listed in the FHCP "*Prescription Drug Formulary*;"
2. A prescription is required even if the medication and/or supplement is available over the counter;
3. The Member meets the specific age and/or other criteria established by the USPSTF; and
4. The Medication and/or Supplement can **ONLY be dispensed at an FHCP Pharmacy**.

Prior Authorization

A medication may require prior authorization in order for it to be covered under a Member's pharmacy benefit. Prior authorizations may be required to check for appropriateness of a medication based on the risks and benefits associated with a medication. Some medications are only used for very specific indications. Prior authorizations may also be required because many medications have alternatives that are equally effective and less costly. FHCP Prior Authorization process is designed to ensure the most cost effective and safest alternatives are prescribed first.

The Prior Authorization request must be submitted to FHCP's Referral Department. The request must include a Physician's statement as to why the drug being requested is medically necessary. Whenever possible, the request should also include other drugs of the same type that the Member has tried and failed, including, any history of previous adverse reactions.

FHCP's Referral Department will make a determination within the timeframes outlined in the "*Pre-Service Claims"* sub-section of the *"Claims Review"* Section. Once the determination is made, both the Member and the prescribing Physician will be notified of the outcome. In the event the determination was to deny the request, the Member may appeal the decision. The appeals process is explained in detail in the *"Complaint, Grievance & Appeal Processes"* Section.

Quantity Limitations

Certain medications have Quantity Limitations to improve safety and cost-effective use. Medications with Quantity Limits can be found in the FHCP "*Prescription Drug Formulary."*

Submission of Claims by Member

There may be certain circumstances when you will be required to pay for your prescription(s) in full at the time it is dispensed such as for emergency services received outside of our Service Area. If you believe the amount(s) you were charged were in excess of your cost-sharing amount and you are seeking reimbursement, you must submit these claims to FHCP's Claims Department within six (6) months after the date the prescription(s) was filled. If it is not reasonably possible to submit a claim in the timeframe required, FHCP will not reduce or deny the claim for this reason, if proof is included with the claim that it was filed as soon as possible *("proof" can be in the form of a written statement explaining the reason(s) for the delay)*. In any event, any claim for reimbursement submitted by a Member must be submitted no later than one (1) year after the date of occurrence unless the Member was legally incapacitated.

When a Member submits any request for medication reimbursement the request must include the following:

1. Copy of dated, paid, cash register receipt; and
2. Copy of the actual, dated, medication receipt indicating the name of the prescribing Physician / Provider, the patient's name, the name of the drug, quantity dispensed and the dosage.

All Member requests for reimbursement must be submitted to FHCP's Claims Department. The address for the Claims Department appears on the Membership card and is listed in the "*Telephone Numbers and Addresses"* sub-section.

Prescription Drug Coverage Exclusions and Limitations

Exclusions: <u>What is NOT covered.</u>

The following are excluded from coverage under the Group Plan's Prescription Drug Coverage:

- Abortifacients;

- Any drug, medicine, or medication that is consumed at the place where the prescription is given or that is dispensed by a Physician;

  Note: Services of this type are considered incidental to a medical or Physician's service and may be considered for coverage under the Member's medical coverage benefits.

- Any drug or medicine that is lawfully obtainable without a prescription (e.g. over the counter (OTC) medications) with the exception of:

  1. USPSTF preventive medications & supplements listed in the FHCP *"Prescription Drug Formulary"* when prescribed by Physician or health care professional (except a pharmacist) acting within the scope of his or her license and obtained at an FHCP Pharmacy; and
  2. Insulin. (*Lancets & glucose strips see the "Covered Medical Services" Section*).

- Any drug for cosmetic use or for the purpose of altering ones' appearance *(e.g. Rogaine, Bleaching Agents, Acne treatment);*

- Any drug used for "Off-label" use. "Off-label" use includes Non-FDA approved indications, indications without guideline or compendial support, non-approved route of administration, or outside the FDA approved age groups, dosage, and/or frequency;

- Any drug prescriptions ordered or received in excess of any maximum covered under this benefit and not covered under any other provisions in the Group's Plan, or medications labeled *"Caution – Limited by Federal Law to Investigational Use;"*

- Any drugs or supplies including, but not limited to, alcohol wipes, gloves, masks, bandages and wound dressings which can be purchased over-the-counter without a prescription or even when a prescription is provided for drugs and supplies that do not require a prescription except covered OTC drugs listed in the "Prescription Drug Formulary" or in the "*Covered Medical Services"* Section of this COC

- Erectile Dysfunction (ED) drugs, Libido Dysfunction Drugs, and drugs to treat Hypoactive Sexual Desire disorder (HSDD);
- Experimental or investigational drugs;
- Immunizing agents, biological serums, or allergy serums;

  Note: These types of drugs may be covered under a Member's medical benefit. See the *"Covered Medical Services"* Section for benefit information.

- Infertility agents;
- Medical Marijuana;
- Non-Formulary injectables and non-self-injectable drugs are excluded;
- Nutritional supplements given as a medicine between meals to boost protein-caloric intake or the mainstay of a daily nutritional plan;

  Note: See the *"Covered Medical Services"* Section for benefit information regarding "*Enteral Formulas."*

- Prescription and non-prescription appetite suppressants and products for the purpose of weight loss;
- Prescriptions prescribed by any health care professional not licensed in any State or territory of the United States;
- Prescriptions purchased through the internet and/or prescriptions purchased outside of the United States;
- Prescription refills in excess of the number specified by the prescribing Physician;
- Prescriptions that are to be taken by, or administered to, the Member in whole or in part, while he or she is a patient in a Hospital, Skilled Nursing Facility, convalescent Hospice, Inpatient Hospice facility, or other facility where drugs are ordinarily provided by the facility on an inpatient basis;

  Note: Services of this type, with the exception of Hospice are considered for coverage under the Member's medical coverage benefits.

- Prescriptions that may be paid without charge to the Member under local, state, or federal programs, including Worker's Compensation, Automobile Insurance, Homeowners Insurance, or any other party that may be responsible as a primary payer;

- Replacement of lost, damaged, or stolen prescriptions;

- The administration of a covered prescription medication; and

  Note: Services of this type may be considered for coverage under the Member's medical coverage benefits.

- Therapeutic devices, appliances, medical or other supplies (*including hypodermic needles / syringes except for insulin syringes/needles),* equipment, and supplements such as medical foods, support garments, creams, gels, and oils regardless of intended use except for covered products listed in the "Prescription Drug Formulary" or the "Covered Medical Services" Section of this COC.

Limitations

- Only medications, approved by the Federal Drug Administration (FDA) for the diagnosis or condition for which it is being prescribed or supported by recognized in the current edition of the United States Pharmacopoeia; American Hospital Formulary Service Drug Information, The DRUGDEX Information System; the USPDI, or the National Comprehensive Cancer Networks and Clinical Pharmacology dispensed at an FHCP Pharmacy, contracted Pharmacy or in the event of a medically covered emergency or urgently needed care services a non-contracted Pharmacy licensed in accordance with Chapter 465 of the *Florida Statutes* or equivalent in another state will be covered.

- Prescriptions filled at a non-network or non-contracted Pharmacy, are not covered except for prescriptions received as part of a medically covered emergency or urgently needed care services.

- Nicotine suppressants and smoking cessation medications unless it is prescribed by a Physician and is one of the USPSTF Preventive Medications and Supplements listed in the FHCP *"Prescription Drug Formulary."*

FHCP reserves the right NOT to apply manufacturer or provider cost-sharing assistance program payments *(e.g. manufacturer cost-sharing, foundations, other third-party payer on behalf of the Member, and/or coupons).*

Prescription Drug Coverage Glossary

Brand Name Drug: A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched, developed and patented the drug.

Compounded Drug: Individual drugs / ingredients mixed together in the exact strength and dosage form prescribed by the physician. To be covered, the drugs/ingredients must be listed on the FHCP "*Prescription Drug Formulary*." Access restrictions apply.

Covered Prescription Drug: The prescription drugs listed on the FHCP "*Prescription Drug Formulary*."

Drug Tier: The cost-sharing level that a drug listed in the formulary has been assigned. In general, the higher the drug's Tier, the higher your cost for the drug.

FDA: The United States Food and Drug Administration.

FHCP Pharmacy: A preferred pharmacy owned and operated by FHCP and listed in the Provider Directory.

Formulary or Drug Formulary: The list of drugs that are covered your Group Plan. FHCP has two formularies: The *"Prescription Drug Formulary*" and The "*Medical Pharmacy Formulary*."

Formulary Exception: A type of determination made by FHCP that, if approved, allows you to get a prescription drug that is not listed on the "*Prescription Drug Formulary*" at a formulary rate.

Generic Drug: A prescription drug that has been approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Medical Pharmacy Formulary: A listing of drugs covered under the Group Plan's Medical benefit. The Formulary includes information regarding any prior authorization or step therapy requirements or quantity limitations.

Non-Preferred Pharmacy: A Non-Preferred Retail Pharmacy is a participating network pharmacy that is listed in FHCP's directory and is not owned and operated by FHCP.

Over the Counter (OTC) Drug: Any drug that can be purchased without a prescription.

Out of Network Pharmacy: Any pharmacy that is not contracted with FHCP.

Preferred Pharmacy: Any FHCP owned and operated Pharmacy.

Prescription Drug Coverage: A type of "Plan" that provides benefits for prescription drugs in addition to medical benefits coverage.

Prescription Drug Formulary: A listing of drugs covered for those Group Plans with a prescription drug benefit. The "*Prescription Drug Formulary*" includes information regarding any prior authorization or step therapy requirements or quantity limitations.

Prior Authorization: A prescription drug listed on the formulary that requires prior approval from FHCP before it can be obtained at a formulary rate.

Quantity Exception: A type of determination made by FHCP that, if approved, allows you to receive a prescription drug listed on the formulary that exceeds a limitation previously established on that drug. FHCP will not approve or dispense a quantity that exceeds the manufacturer or FDA dose limits.

Quantity Limit: A medication management tool that is designed to limit the use of a selected prescription drug for quality, safety or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time such as one month. The limit may be established by the FDA, FHCP and/ or the manufacturer.

Self-Injectable: A prescription drug that you can inject yourself and is not required to be administered by a physician or other licensed professional.

Step Therapy Drug: A utilization tool in which a prescription drug requires you to first try another prescription drug to treat your medical condition prior to obtaining that specific drug at the Formulary rate.

United States Preventive Services Task Force (USPSTF): An independent, volunteer group of physicians and other clinicians with expertise in prevention and evidence-based medicine. This group makes recommendations about clinical preventive services such as screenings, counseling or preventive medications to improve the health of all Americans.

Usual and Customary Price: The cost of a drug to the consumer at the current retail level without the use of insurance. The U&C price rate is often referred to as the "*cash price*" for patients.

Section 20: Statement on Advance Directives

The following information is provided in accordance with the Patient Self-Determination Act to advise you of your rights under Florida law to make decisions concerning your medical care, including your right to accept or refuse medical or surgical treatment, the right to formulate an Advance Directive, and explain the policy of FHCP with respect to Advance Directives. The information is general and is not intended as legal advice for specific needs. You are encouraged to consult with your attorney for specific advice.

Florida law recognizes the right of a competent adult to make an Advance Directive instructing his or her Physician to provide, withhold, or withdraw life-prolonging procedures, or to designate another to make treatment decisions for him or her in the event that such person should be found to be incompetent and suffering from a terminal condition. Advance Directives provide patients with a mechanism to direct the course of their medical treatment even after they are no longer able to consciously participate in making their own healthcare decisions.

An "*Advance Directive*" is a witnessed oral or written statement which indicates the individual's choices and preferences with respect to medical care made by the individual while he or she is still competent. An Advance Directive can address such issues as whether to provide any and all health care, including extraordinary life-prolonging procedures, whether to apply for Medicare, Medicaid or other health benefits, and with whom the health care provider should consult in making treatment decisions.

There are three types of documents recognized in Florida commonly used to express an individual's Advance Directives: A Living Will, a Healthcare Surrogate Designation, and a Durable Power of Attorney for Healthcare.

A Living Will

This is a declaration of a person's desire that life-prolonging procedures be provided, withheld, or withdrawn in the event that the person is suffering from a terminal condition and is not able to express his or her wishes. It does not become effective until the patient's Physician and one other Physician determine that the patient suffers from a terminal condition and is incapable of making decisions.

Another common form of advance directive is the:

Healthcare Surrogate Designation

When properly executed, a Healthcare Surrogate Designation grants authority for the surrogate to make health care decisions on behalf of the patient in accordance with the patient's wishes. The surrogate's authority to make decisions is limited to the time when the patient is incapacitated and must be in accordance with what the patient would want if the patient was able to communicate his or her wishes. While there are some decisions which by law the surrogate cannot make, such as consent to abortion or electroshock

therapy, any specific limits on the surrogate's power to make decisions should be clearly expressed in the Healthcare Surrogate Designation document.

Finally, there is the:

Durable Power of Attorney for Healthcare

This document, when properly executed, designates a person as the individual's attorney-in-fact to arrange for and consent to medical, therapeutic, and surgical procedures for the individual. This type of advance directive can relate to any medical condition.

Additional Information

A suggested form of Living Will and Designation of Healthcare Surrogate is contained in Chapter 765 of the *Florida Statutes*. There is no requirement that a patient has an advance directive and your health care provider cannot condition treatment on whether or not you have one. Florida law provides that, when there is no advance directive, the following persons are authorized, in order of priority, to make health care decisions on behalf of the patient:

1. A judicially appointed guardian;
2. A spouse;
3. An adult child or a majority of the adult children who are reasonably available for consultation;
4. A parent;
5. Adult siblings who are reasonably available for consultation;
6. An adult relative who has exhibited special care or concern, maintained regular contact, and is familiar with the person's activities, health and religious or moral beliefs; or
7. A close friend who is an adult, has exhibited special care and concern for the person, and who gives the health care facility or the person's attending Physician an affidavit stating that he or she is a friend of the person who is willing to become involved in making health care decisions for that person and has had regular contact with the individual so as to be familiar with the person's activities, health, religious, and moral beliefs.

Deciding whether to have an Advance Medical Directive, and if so, the type and scope of the directive, is a complex understanding. It may be helpful for you to discuss Advance Directives with your spouse, family, friends, religious or spiritual advisor, or attorney. The goal in creating an advance directive should be for a person to clearly state his or her wishes and ensure that the health care facility, Physician, and whoever else will be faced with the task of carrying out those wishes knows what you would want.

It is the policy of FHCP to recognize the right of each Member to make health care treatment decisions in accordance with your own personal beliefs. You have a right to decide whether or not to execute an Advance Directive to guide treatment decisions in

the event you become unable to do so. FHCP will not interfere with your decision in accordance with the laws of the State of Florida.

It is your responsibility to provide notification to your providers that an Advance Directive exists. If you have a written Advance Directive, we recommend that you furnish your providers and FHCP with a copy so that it can be made a part of your medical record.

Pursuant to Section §765.1105, *Florida Statutes*, Florida law does not require a health care provider or facility to commit any act which is contrary to the provider's or facility's moral or ethical beliefs. A health care provider or facility that refuses to comply with your Advance Directive *(Or decision of your Health Care Surrogate)* will make every reasonable effort to transfer you to another provider or facility that will comply with your decision as long as you are not in an emergency condition; and you have given your provider or the facility a copy of your written Advance Directive. In addition, you have the right to request treatment from another provider or facility that will carry out your wishes *(Or the wishes of your Health Care Surrogate).*

FHCP providers have, in accordance with State law, varying practices regarding the implementation of an individual's Advance Directive. Therefore, we recommend that you have discussions about Advance Directives with your medical care givers, family members and other friends and advisors. Your Physician should be involved in the discussion and informed clearly and specifically of any decisions reached. Those decisions need to be revisited in light of the passage of time or changes in your medical condition or environment.

For assistance in obtaining Living Will, Organ Donor and Health Care Surrogate State of Florida forms, please contact FHCP's Member Services at the address and telephone number listed in the "*Telephone Numbers and Addresses"* sub-section.

We hope this information has been helpful to your understanding of your rights under the Patient Self-Determination Act and Florida law.

Section 21: Members' Rights & Responsibilities

FHCP is committed to providing Members with health care and related services through dedicated employees and services partners who manage both the quality and the cost of health care. Our vision is to set the standard for health care in our community. We intend to be acknowledged as the leader by our Members, Employees, Service Partners, and Governing Body. In our community we manage both the quality and the cost of health care provided to the Members of our health plan. We are committed to understanding the health care needs and meeting the requirements of our Members, fellow Employees, and Service Partners. We will strive to do our jobs right the first time, every time.

As a Member of FHCP you have certain rights and responsibilities. Your rights are in keeping with FHCP's commitment to provide you with quality care and services at a reasonable cost. Your responsibilities are to assist us in achieving this goal.

Rights

1. To a reasonable response to your request and need for treatment or service within FHCP's capacity, and applicable laws and regulations.
2. To be informed about, consent to, or refusal of, recommended treatment.
3. To present Grievances without compromise to future health care if you feel these rights have not been provided.
4. To file an Appeal. *(*See the *"Complaint, Grievance and Appeal Processes"* Section of this Certificate of Coverage.)
5. To be treated with dignity and consideration as an individual with personal value and belief systems, with compassion and respect, with reasonable protection from harm, and with appropriate privacy.
6. To receive quality health care with respect and dignity regardless of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, sexual identity, claims experience, medical history, evidence of insurability, conditions arising out of acts of domestic violence, disability, genetic information, or source of payment.
7. To be informed about your diagnoses, treatments, and prognoses. When concerns for your health make it inadvisable to give such information to you, such information will be made available to an individual designated by you or to a legally authorized individual.
8. To be assured of confidential treatment of disclosures and records; and to be afforded an opportunity to approve or refuse the release of such information, except when release is required by law.

9. To refuse treatment to the extent permitted by law and be informed of the consequences of your refusal. When refusal of treatment by the Member or his/her legally authorized representative prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the Member may be terminated upon reasonable notice.
10. To participate in decisions involving your health care, including ethical issues and cultural and spiritual beliefs, unless concerns for your health contraindicate.
11. To information about FHCP, it's providers and practitioners as well as your Member rights and responsibilities.
12. To participate in discussions involving medically necessary treatment options regardless of cost and/or benefit coverage.
13. To refuse to participate in experimental research.
14. To know the name of the Physician coordinating your health care and to request a change, verbally or in writing, of your Primary Care Physician.
15. To make decisions concerning such medical care, including the right to accept or refuse medical treatment or surgical treatment and the right to formulate Advance Directives (*e.g. "Living Wills, etc*.) in accordance with the Federal Law titled "Patient Self Determination Act" and the Chapter 765 of the *Florida Statutes*, "Health Care Advance Directives." These rights shall also include the right to appoint another either by Power of Attorney or by designation of a Health Care Surrogate to make Health Care Decisions for you and to provide informed consent if you are incapable of doing so.
16. To make recommendations regarding the Organization's *(FHCP's)* Member Rights and Responsibilities policy.
17. To be informed of what support services are available at no charge to you, including but not limited to, interpreter services in the language of your choice.

Responsibilities

1. To provide accurate and complete information about present complaints, past illnesses, medications, and unexpected changes in your condition.
2. To promptly respond to FHCP's request for information regarding you and/or your dependents in relation to covered services**.**
3. To understand, ask questions and follow recommended treatment plan(s) to the best of your ability.
4. To understand your health problems and to participate in developing mutually agreed upon goals to the best of your ability.
5. To keep appointments reliably and arrive on time or to notify the provider, ideally 24 hours in advance, if you are unable to keep an appointment.
6. To follow safety rules and posted signs.

7. To demonstrate respect and consideration towards medical personnel and other Members.
8. To understand that you are responsible for your actions and the possible consequences if you refuse treatment or do not follow the provider's instructions.
9. To receive all your health care through FHCP with the exception of emergency care. (Members with a *Point-of-Service or Triple Option Plan* see your *"Summary of Benefits and Coverage"* and *"Schedule of Benefits."*)
10. To know your medicines and take them according to the instructions provided.
11. To report emergency treatment to FHCP at the telephone number listed in the "*Telephone and Addresses"* sub-section as soon possible.
12. To present your FHCP membership identification card each time you drop off and pick up a prescription.
13. To use emergency room facilities only for medical emergencies and serious accidents.
14. To be financially responsible for any copayments, coinsurance, and/or deductibles.
15. To provide current information concerning your FHCP membership status to your provider.

Disclosure of Continuing Care Facility Resident / Retirement Facility Resident Member Rights

If, at the time of enrollment as a Member of FHCP, the Member is a resident of a continuing care facility certified under Chapter 651 of the *Florida Statutes*, or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, the Member's Primary Care Physician must refer the Member to that facility's skilled nursing unit or assisted living facility if:

1. Requested by the Member and agreed to by the facility;
2. The Member's Primary Care Physician finds that such care is Medically Necessary;
3. The facility agrees to be reimbursed at the FHCP contract rate with similar providers for the same Covered Services and supplies; and
4. The facility meets all guidelines established by FHCP related to quality of care, utilization, referral authorization, risk assumption, use of the FHCP provider network, and other criteria applicable to providers under contract with FHCP for the same Services.

If a Member's request to be referred to the skilled nursing unit or assisted living facility that is part of that Member's place of residence is not honored, the Member has the right to initiate a Grievance or Appeal under the process described in the Certificate of Coverage.

Additional Information:

Members may contact the FHCP Member Services Department at the phone number listed in the "*Telephone Numbers and Addresses"* sub-section to request information regarding the FHCP Organization including but not limited to the results of any public survey information such as access, quality of care and satisfaction. The Member Services Department can provide you with information about the professional qualifications of our contracted practitioners, such as medical school, residency training, hospital affiliations and board certifications. Members may also access this type of information at the following State of Florida website:

https://www.floridahealth.gov/licensing-and-regulation/practitioner-profile/index.html

Translation Services

FHCP's Member Services Department and staff has immediate access to over 200 languages and can offer our Members assistance and information, including written materials, in the language of your choice. Our Member Services Department can also assist your health care provider should you and your provider require access to a Translation Service to aide in the delivery of your care.

Section 22: Complaint, Grievance, & Appeal Processes

Introduction

FHCP has established a process for reviewing Member Complaints, Grievances, and Appeals. The purpose of this process is to facilitate review of, among other things, the Member's dissatisfaction with FHCP's administrative practices, coverage, benefit, payment decisions, or with the administrative practices, and/or the quality of care provided by any Contracted Provider.

Examples of a Grievance / Complaint Include but Are Not Limited To:

Access: Examples of Access issues include; the time to wait for an appointment, the wait time in the provider's office, the wait for a phone call, appointment scheduling issues, delay in services, and/or cancellations.

Customer Service / Satisfaction: The way you were treated by an employee of FHCP, Physician's staff, Physician, and/or any provider of a covered service.

Policy & Procedure: Including but not limited to the general, overall benefits of your plan and/or the amount you must pay for those benefits.

Quality: Any quality issue you have related to the services, supplies and/or facilities you have received or utilized that are covered under your plan.

The Complaint, Grievance, and Appeal Process also permit you or your Physician to Expedite FHCP's review of certain types of Grievance and Appeals.

Helpful Definitions of Terminology Frequently Used in This Section

Appeal: Refers to any written request for a review of a denied Pre-Service or Post-Service Claim, Discontinued Service that you are currently receiving, and Rescission of Eligibility.

Note: Only an "*Expedited Appeal*" request regarding a Prior Authorization, Concurrent Care, or Reduction or Termination of a Service you are currently receiving may be submitted to FHCP's Member Services Department either verbally or in writing.

Authorized Representative of a Member means a person a Member has designated **both** verbally and in writing to represent him/her in the filing of a complaint, grievance, or an appeal. In the event the Member is a minor dependent child the authorized representative is automatically the parent or legal guardian.

Complaint: Refers to an Enrollee contacting FHCP's Member Services Department either by telephone or in person.

Grievance: Refers to any written, formal complaint received from an Enrollee.

NOTE: A “Fast” or “Urgent” Grievance regarding access, quality of care, FHCPs decision to transfer a request for an expedited appeal to a standard timeframe, or FHCP’s request for an extension of a timeframe for processing an appeal, may be submitted to FHCP’s Member Services Department either verbally or in writing.

Complaint and Grievance Processes

Informal Review - Complaints

To report a Complaint, you should contact FHCP’s Member Services Department either by telephone at: 1-877-615-4022 or (386) 615-4022. (*Hearing impaired may utilize the Florida Relay Line 711*); or you may also report your complaint in person by appointment or walking in. FHCP’s Member Services Department is located at: 1510 Ridgewood Avenue, Holly Hill, FL 32117.

Upon receipt of your Complaint the Member Services Department will work with the appropriate personnel, will review the Complaint within a reasonable time, not to exceed 30 calendar days after its submission, and attempt to resolve the issue to your satisfaction.

FHCP’s Member Services Department will provide you with any assistance you may require related to your Complaint. They can assist in obtaining a sooner appointment whenever possible or with contacting your Provider’s office

You must provide all the facts relevant to the Complaint to the Member Services Department. Failure to provide any requested or relevant information may delay FHCP’s review of the Complaint and your Complaint must be filed within 180 days of the adverse occurrence.

Standard Grievance

In order to begin the formal review process, you or your authorized representative. (See definition of an “Authorized Representative of the Member” in the *“Glossary*” Section) must write a letter or send an e-mail or fax to FHCP’s Member Services Department explaining the facts and circumstances related to the Grievance (a “Formal Complaint”).

You must provide as much detail as possible and attach copies of any relevant documentation.

The Grievance must be filed with FHCP’s Member Services Department within 180 days of the date of the adverse occurrence. (See the *“Telephone Numbers and Addresses”* sub-section.)

FHCP’s Member Services Department will review the Grievance with the appropriate Plan Administration Representatives and/or the Clinical Review / Benefits Review Panel in accordance with the standard Grievance Procedure and advise you of its findings in writing within 30 calendar days of receipt of the Grievance.

Urgent / Expedited Grievance:

If you have an issue/complaint such as access to, or quality of, care and you believe that the standard complaint or grievance timeframe could seriously jeopardize your life or health, you can request an "Urgent / Expedited" Grievance. Your request for an Urgent / Expedited Grievance may be made either verbally or in writing (*including e-mail*).

Once FHCP's Member Services Department has established your request does meet expedited criteria they will review the Grievance and provide any necessary assistance to you within 24 not to exceed 72 hours.

Examples of a qualifying Urgent / Expedited Grievance are:

1. There is a delay in access to care or concern with the quality of the care received; AND
2. A delay in resolving the access or quality issue under the standard Grievance procedure timeframe (30 calendar days) could seriously jeopardize your life or health, or your ability to regain maximum function, or in the opinion of a Physician with knowledge of your Condition, would subject you to severe pain that cannot be adequately managed with the care of treatment that is the subject of the Grievance.

Fast Grievance

If you disagree with FHCP's decision to transfer a request for an expedited prior authorization for a service to a standard timeframe or a request for an expedited appeal to a standard timeframe (*Expedite*d *Initial Prior Authorization Request 24-72hours to a Standard 15-day timeframe; or Expedited Prior Authorization Appeal to Standard 30-day timeframe*).

or

You disapprove of FHCP extending the timeframe of a Prior Authorization, Concurrent Care Review, Grievance, or an Appeal by an additional 14 days; you may request a "Fast Grievance".

You or your authorized representative may request a Fast Grievance by phone, by e-mail, or by fax. Upon receipt of your request FHCP's Member Services Department will immediately review your concerns and provide you with a final answer to your request within 24 hours.

Appeal Processes

Overview

Whenever a request for a Service (*Prior Authorization*), a request for Continuation or Reduction of a Service you are currently receiving *(Concurrent Care),* or a Request for Payment or Reimbursement *(Claim)* has been denied either fully or in part, are referred to as an *"Adverse Determination*."

All written notices of an Adverse Determination will include your right to file an Appeal, instructions on how to file an Appeal and the timeframe in which you must file your Appeal.

There are 2 types of Appeals; Standard or Expedited. Each type of Appeal is subject to the same processes. However, the timeframes for each will be different depending on the nature of the Service being appealed.

The following sub-sections detail each type of Appeal and the respective timeframes associated with the nature of the Service being appealed.

All the following types of Appeals are subject to a "***Level One (1)*"** Appeal process. Level One Appeal Processes are coordinated by, and completed through, FHCP's Member Services Department.

"Level Two (2)" Appeals are available to you in the event your *Level One (1)* Appeal request is unfavorable to you and results in a Full or Partial Denial.

The Level Two *(2)* Appeal Processes are handled by an entity outside, and independent of, FHCP. The review entity for all Level Two Appeal processes is referred to as an External Review Organization or ERO. This process will be explained to you later in this Section.

To file an Appeal see the "*Telephone Numbers and Addresses"* sub-section.

All the following are Types of Appeals

Standard Appeals

In order to begin the formal Appeal Process, you or your authorized representative (See definition of an *"Authorized Representative of a Member"* in this Section and the *"Glossary"* Section) must write a letter requesting an Appeal within 180 days of the adverse determination and, when applicable, include any relevant documentation supporting your request.

Prior Authorization Standard Appeal

If the Appeal is regarding a denied Prior Authorization Request for Service you have not yet received you, your authorized representative, your physician, or your health care provider who requested the Service **with written Authorization from you** to act on your behalf, may file the Appeal in writing by USPS, fax, or e-mail directly to FHCP's Member Services Department.

Timeframe

For Appeals involving a Prior Authorization request for Service you have yet to receive FHCP's Member Services Department will complete the entire Level One Appeal Process and notify you of the final determination within 30 calendar days of receipt of the Appeal.

On occasion FHCP may require additional documentation that would benefit you. In this circumstance FHCP will ask you for an extension. The maximum allowable extension is 14 calendar days.

In the event FHCP requests a 14-calendar day extension, FHCP will advise you verbally and in writing of the need and the reason for the extension. This notification will include your right to file a Fast Grievance. The "*Fast Grievance*" process was previously described in this Section. If the requested "*Fast Grievance*" was Favorable to you FHCP will complete the Level One Appeal process within the required 30 calendar day timeframe.

Claims *(aka "Post Service")* are Always a Standard Appeal

If the Appeal is regarding a denied Claim, or FHCP has denied your request for Payment or Reimbursement for a Service you have already received, it will only be processed in accordance with the Standard "*Claim Appeal*" timeframe.

You, your authorized representative (See definition of an *"Authorized Representative"* in the *"Glossary"* Section), or a Provider **with written authorization from you** to act on your behalf, **must write** a letter requesting an Appeal within 180 days of the date of FHCP's notice of Adverse Determination and, when applicable, include any relevant documentation supporting your request.

Timeframe

FHCP's Level One process and notification of the final determination regarding the Appeal of a denied Claim will be made within 60 calendar days of receipt of the Appeal.

The timeframe for Appeals regarding any service you have already received is not allowed to be extended.

Expedited Appeals:

If the Appeal is regarding the Termination, Reduction or Discontinuation of a Service you are currently receiving, you, your Authorized Representative, or your Physician or Provider acting on your behalf, may request that the review of the Appeal be "Expedited."

On occasion an Appeal regarding a denied Prior Authorization may be requested as expedited provided the following very specific criterion is met:

A delay in the provision of Health Care Services being Appealed for the length of time permitted under the standard Appeal procedure timeframe (Approximately 30 calendar days) could seriously jeopardize your life or health, or your ability to

regain maximum function, or in the opinion of a Physician with knowledge of your Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Appeal.

The request for an Expedited Appeal may be made by telephone, fax, or e-mail.

On occasion, FHCP will receive a request for an Expedited Appeal that does not meet Expedited Criteria. Meaning:

In the opinion of a Physician Reviewer transferring your request for an Expedited Appeal to the Standard Appeal timeframe of 30 days would not seriously jeopardize your life or health, or your ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed with the care or treatment that is the subject of the Appeal.

In the event your request for an Expedited Appeal is transferred to a Standard timeframe, FHCP will notify you verbally and in writing of transfer. Both notifications will include your right to file a "Fast Grievance."

If you choose to file a Fast Grievance and your Fast Grievance was Favorable to you, FHCP will complete the Level One Appeal process within the required 24 not to exceed 72-hour timeframe.

Timeframe

FHCP will complete the entire Level One process and notify you of the decision, as expeditiously as the Condition requires within 24 hours, but in no event longer than 72 hours after receipt of the request for "*Expedited"* review.

If additional information is necessary, FHCP will notify you and the Physician or Provider within 24 hours of receipt of the Appeal involving Concurrent Care or Prior Authorization. FHCP must receive the requested additional information within 48 hours of making the request.

Under no circumstance will the processing of any request for an Expedited Appeal exceed 72 hours.

Required Information necessary to evaluate an Expedited Appeal regarding a Concurrent Care or Prior Authorization Appeal may be transmitted by telephone, fax, e-mail, or other fast method.

Note: If your request for an Expedited Appeal arises out of a Utilization Review determination by FHCP that a continued Inpatient stay or continuation of a course of treatment is not Medically Necessary, coverage for the Hospitalization or course of treatment will continue until you have been notified by FHCP of the final determination of the Appeal.

Level One Appeal Processes

Initial Review of Appeals

The Appeal will be reviewed by a licensed professional(s) who was not involved in the Initial Adverse Determination and whose specialty or level of care would include the type of Service(s) being requested.

If this initial review is not favorable to you, the Appeal will automatically be forwarded to FHCP's Clinical Review / Benefit Review Panel as described in the "*Clinical Review / Benefit Review Panel*" sub-section below.

The Clinical Review / Benefit Review Panel

FHCP's Clinical Review / Benefit Review Panel consist of a group of licensed professionals including Physicians licensed in accordance with the *Florida Statutes*.

The Physician reviewer(s) will be of the same or like specialty of the service(s) being Appealed and will not have been involved in making either the Initial Adverse Determination (*Initial Denial*) or the initial review of the request for an Appeal.

The Clinical Review / Benefit Review Panel Process

In the event the initial review of your Appeal request was not fully favorable (was Adverse) to you, the Appeal will be forwarded automatically to FHCP's Clinical Review / Benefit Review Panel for final determination.

An Adverse or unfavorable initial review of an Appeal is a determination made that based on the information provided, an admission, availability of care, continued stay, Heath Care Service, Payment for a Health Care Service, requirements for Medical Necessity, Appropriateness, Health Care Setting, Level of Care, Effectiveness, or Benefit Coverage, FHCP will then automatically forward the Appeal to FHCP's Clinical Review / Benefit Review Panel for a final determination.

Following the receipt of the Appeal, whenever necessary, the Clinical Review / Benefit Review Panel will make its final determination within the allotted timeframes below:

1. 30 calendar days for a Standard Prior Authorization Appeal;
2. 60 calendar days for a Standard Post Service Claim; and
3. Within 24 hours not to exceed 72 hours for an Expedited Appeal

Notification of Level One Determinations

All notifications of Level One Determinations will be issued within the timeframes listed above**.**

Fully Favorable Appeal Determinations

Standard Prior Authorization Appeals

In the event an Appeal for previously denied "Prior Authorization" for Services you have yet to receive is Fully Favorable to you FHCP's Member Services Department will notify you and/or your Provider verbally of the approval. The Member Services Department will generate an approved authorization and notify the Physician or Provider of the Service(s) requested of the approval.

Standard Post Service Claims Appeals

If an Appeal regarding a denied *"Claim or Request for Payment or Reimbursement*" is Fully Favorable to you, FHCP's Member Services Department will notify you of the approval. The Member Service Department will generate an internal authorization for payment to FHCP's Claims Department notifying that Department to reprocess the Claim that was appealed in accordance with your Group Health Plan benefits, minus any applicable cost-sharing amount(s).

Expedited Appeals

FHCP's Member Services Department will notify you and /or your Provider (*Prior Authorization & Expedited Appeals)* verbally of any Fully Favorable Determinations within the timeframes indicated above.

If the appeal was regarding an Inpatient admission, Continuation, Reduction, or Termination of Services you are currently receiving, and the determination is fully favorable the services will continue without interruption.

In the case of a termination of Service, the Service will resume.

Adverse Appeal Determinations

Manner and Content of a Notification of an Adverse Appeal Determination:

In the event the Level One Appeal was denied in whole or in part, FHCP's Member Services Department will notify you both verbally and in writing of the Adverse Appeal Determination.

The written Notification will:

1. List the specific reason or reasons for the Adverse Appeal Determination;
2. Refer to any specific Plan benefit from the "*Schedule of Benefits*" and/or "*Summary of Benefits*" upon which the Adverse Appeal Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Appeal Determination;

3. Describe any additional information that might change the determination and why that information is necessary;
4. If the Adverse Appeal Determination is based on the "Medical Necessity" or "Experimental or Investigational Exclusion or Limitation," the notice will include any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Appeal Determination;
5. A statement telling you how to obtain the specific explanation of the scientific or clinical judgment for the utilized in making the final Adverse Appeal Determination;
6. A statement advising you that you may request a copy of the documentation utilized in the Appeal Case file to make the final Adverse Appeal Determination free of charge; and
7. Your right to, and instruction for, filing a Level Two (2) Appeal.

   Level two appeals for Non-Grandfathered Plan Members are filed with Maximus Federal Services, a federally qualified External Review Organization (ERO).

   Level two appeals for Members enrolled in a Grandfathered Plan are filed with an independent External Review Organization (ERO).

   The information you receive will include the timeframe in which to file a Level Two Appeal request; the Maximus Federal Services Federal Service or the Independent ERO's contact information; and any forms the applicable ERO may require when requesting an Appeal.

   (See the "Glossary" Section for the definitions of a "Grandfathered" and "Non-Grandfathered Plan.")

Level Two (2) Appeal Processes

Grandfathered Plan – Independent External Review Organization

Once you have completed the "*Level One*" Appeal Process you will be advised both verbally and in writing of your right to have an Appeal reviewed by an "*Independent External Review Organization*" (ERO). An Independent ERO is an organization consisting of a full range of Clinical Professionals and Medical Specialists who were not involved with either the Initial "*Adverse Determination*" or the "*Adverse Appeal Determination*." The Independent ERO also has no affiliation with FHCP.

As stated previously, the notice of Adverse Appeal Determination that you receive will include all necessary information to request a Level Two Appeal with the Independent ERO.

In the event the final determination by the Independent ERO is favorable to you, FHCP will provide or approve the Service, or make payment on the Service(s) in question within the Independent ERO's required timeframe. FHCP will notify both you and the ERO of the effectuation of the approval or payment as required.

In the event the Independent ERO upholds FHCP's Adverse Appeal Determination and is unfavorable to you either in whole or in part there are no further levels of appeal available to you through the Plan.

The Independent ERO will only accept Appeals after you have completed the Level One Appeal Process. The Independent ERO will not accept Grievances.

Non-Grandfathered Plan – Maximus Federal Services External Review Organization

Once a Member in a ***"Non-Grandfathered Plan"*** (See the "*Glossary"* Section for the definition of a *"Non-Grandfathered Plan"*) has completed the FHCP Appeal Process the Member will be advised both verbally and in writing of their right to have an Appeal reviewed under the Health and Human Services (HHS) Federal External Review Process. This review is performed by an accredited External Review Organization not affiliated with FHCP. FHCP utilizes Maximus Federal Services as its ERO.

The Member may submit the Appeal to Maximus Federal Services within four (4) Months of the Clinical Review / Benefit Review Panel's decision. Telephone number and address are listed in the "Telephone Numbers and Addresses" sub-section.

Maximus will allow the Member to file an appeal with FHCP and with Maximus Federal Services at the same time only when the appeal is expedited *(A service the Member has not received OR a service the Member is currently receiving*). Maximus Federal Services will make the final determination if they will process the Member's request for a simultaneous review.

Maximus Federal Services will only accept Appeals; it will not accept Grievances.

Telephone Numbers and Addresses

The Member may contact an FHCP Grievance Supervisor at the number listed on the Membership Card or the numbers listed below. If a Grievance is unresolved, the Member may, at any time, contact an agency at the telephone numbers and addresses listed below.

Department of Financial Services
Office of Insurance Regulation
200 East Gaines Street
Larson Building
Tallahassee, Florida 32399-0322
1-877-693-5236
https://www.myfloridacfo.com/division/consumers/

HHS Federal External Review Process
Maximus Federal Services, Inc.
3750 Monroe Avenue
Suite 705
Pittsford, NY 14534
1-888-866-6205

IMPORTANT PLAN NUMBERS

Florida Health Care Plans
Attention: Case Management
2450 Mason Avenue
Daytona Beach, FL 32114
1-386-676-7187
1-866-676-7187
(TRS Florida Relay 711)

Florida Health Care Plans
Attention: Claims Department
P.O. Box 10348
Daytona Beach, FL 32120-0348
1-800-352-9824 extension 5010

Florida Health Care Plans
Attention: Grievance / Appeals
P.O. Box 9910
Daytona Beach, FL 32120-9910
1-386-615-4022
1-877-615-4022
(TRS Florida Relay 711)
Fax 1-386-676-7149

Florida Health Care Plans
Member Services Department
1510 Ridgewood Ave.
Holly Hill, Florida 32117
1-386-615-4022
1-877-615-4022
(TRS Florida Relay 711)
Fax 1-386-676-7149
https://www.fhcp.com/

Florida Health Care Plans
Pre-Certification Emergency Care Utilization and Case Management
Telephone Number
1-386-238-3230
1-800-352-9824

Florida Health Care Plans
Translation Services
(Access to over 150 languages)
Attention: Member Services Department
1510 Ridgewood Ave.
Holly Hill, Florida 32117
1-386-615-4022
1-877-615-4022
(TRS Florida Relay 711)

Section 23: BlueCard® & Blue Cross Blue Shield Global® Core Program

Overview

FHCP has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association *("Association"*). Whenever you obtain healthcare services outside of FHCP's Service Area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside of FHCP's Service Area you will receive it from one to two kinds of providers. Most providers *("participating providers")* contract with the local Blue Cross and/or Blue Shield *(Licensee / Plan)* in geographic area the "*Host Blue*." FHCP explains below how we pay both kinds of providers.

IMPORTANT REMINDER: FHCP covers only limited healthcare services received outside of our Service Area. As used in this Section, "Out-of-Area Covered Healthcare Services" only include emergency and pre-authorized services received outside of FHCP's Service Area. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless specifically authorized by FHCP. (*See the "Coverage Access Rules Section of this Certificate of Coverage, your Plan "Summary of Benefits and Coverage," and "Schedule of Benefits.")*

Members with Point-of-Service or Triple Option Plans see the "*Coverage Access Rules*" Section.

Inter-Plan Arrangements Eligibility – Claim Types

All urgently needed care, emergency, and FHCP authorized claim types are eligible to be processed through Inter-Plan Arrangements as described above.

For Members enrolled in an FHCP Plan that includes Prescription Drug, Dental, and/or Vision Care Benefits, those benefits are not eligible under the Inter-Plan Arrangements and are administered directly by FHCP or, a third party that is contacted directly with FHCP for one or more of these services.

BlueCard® Program

Under the BlueCard® Program, when you receive Out-of-Area Covered Healthcare Services within the geographic area service by a ""Host Blue"", FHCP will remain responsible for doing what we agreed to in this Certificate of Coverage. However, the "Host Blue" is responsible for contracting with, and generally handling, all interactions with its participating providers.

The BlueCard® Program enables you to obtain Out-of-Area Covered Healthcare Services as defined above, from a healthcare provider participating with a ““Host Blue””, where available. The participating provider will automatically file a claim for the Out-of-Area Covered HealthCare Services provided to you so there are no claim forms for you to fill out. You will be responsible for the applicable cost-sharing amount as stated in your *“Summary of Benefits and Coverage”* and *“Schedule of Benefits.”*

Emergency and Urgently Needed Care Services:

If you have a medical Emergency or require Urgently needed care while traveling outside FHCP’s Service Area go to the nearest Emergency or Urgent Care Facility or call 911 to receive treatment.

When you receive Out-of-Area Covered Health Care Services outside of FHCP’s Service Area and the claim is processed through the BlueCard® Program the amount you pay for the Out-Of-Area Covered Healthcare Services will be based on your applicable cost-sharing amount as stated in your *“Summary of Benefits and Coverage”* and *“Schedule of Benefits”* calculated based on the lower of:

- The billed covered charges for your covered services / billed charges for your Out-Of-Area Covered Healthcare Services; or
- The negotiated price that the “Host Blue” makes available to FHCP.

Often this “negotiated price” will be a simple discount that reflects the actual price that the “Host Blue” pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or under-estimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price FHCP has used for your claims

In the event, Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to your account, FHCP will include any such surcharge, tax, or other fee as part of the claim charge passed on to you.

Non-participating Providers Outside FHCP’s Service Area

Non-emergency care received outside of FHCP’s Service Area is not covered unless you have a Point of Service *(POS)* or Triple Option Plan **or** you have received Prior Authorization from FHCP.

For Members enrolled in a Point of Service (POS) or Triple Option Plan: See your “*Summary of Benefits and Coverage”* and “*Schedule of Benefits*” for your applicable cost-sharing amount.

For Members enrolled in an HMO Plan: In the event non-emergency services from a Non-Contracted Provider are required or received, payment for such services will only be made if Prior Authorization was obtained from FHCP. The Member's Primary Care Physician or Contracted Specialist who is treating the Member is responsible for obtaining prior authorization.

Note: Prior authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition.

All Members please see "Coverage Access Rules" Section in this Certificate of Coverage

Blue Cross Blue Shield Global® Core Program

If you are outside the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands you may be able to take advantage of the Blue Cross Blue Shield Global® Core Program when obtaining Covered Services. The Blue Cross Blue Shield Global® Core Program is unlike the BlueCard® Program available in the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands in certain ways.

For instance, although the Blue Cross Blue Shield Global® Core Program assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a "Host Blue." As such, when you receive care from providers outside the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services *(including locating a doctor or hospital)* outside the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands you should call the FHCP Member Services Department at 1(877) 615-4022 or locally at (386) 615-4022. *(Hearing impaired may also utilize TTY: TRS Relay 711).* You may also call the Blue Cross Blue Shield Global® Core Program Service Center at 1(800)810-BLUE (2573) or call collect 1(804) 673-1177 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment of hospitalization, if necessary.

The Member must contact his/her Primary Care Physician and FHCP within 48 hours after the Emergency service is rendered. Any additional care and services required as a result of the emergency (*Inpatient or Outpatient*) and post stabilization care must be prior authorized by FHCP.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global® Core Program Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your applicable cost-share. In such cases, the hospital will submit your claims to begin claims processing. However, if you paid in full at the time of service you must submit a claim to receive reimbursement for any covered services.

Unless you are enrolled in a Point of Service or Triple Option Plan, you must obtain Prior Authorization from FHCP for all non-emergency inpatient services.

Outpatient Services

Physicians, Urgent Care Centers and other outpatient providers located outside the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands will typically require you to pay in full at the time of service. You must file a claim to obtain reimbursement for Covered Services.

Unless you are enrolled in a Point of Service or Triple Option Plan, you must obtain Prior Authorization from FHCP for all non-emergency outpatient services.

Submitting a BlueCard® or Blue Cross Blue Shield Global® Core Program Claim

When you pay for Covered Services outside FHCP's Service Area, you must submit a claim to obtain reimbursement. Please see the "*Submission of Claims by Member"* sub-section of the *"Claims Review"* Section of this Certificate of Coverage for step-by-step instructions on how to submit a claim for reimbursement. If you have any questions, please contact FHCP's Member Services Department at 1(877) 615-4022 or locally at (386) 615-4022. (*Hearing impaired may also utilize TTY: TRS Relay 711.*) You can also go online at http://www.bcbsglobalcore.com or should call the Blue Cross Blue Shield Global Core Service Center at 1(800) 810-BLUE (2583) or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week.

IMPORTANT: See the "*Coverage Access Rules*" Section; *"Emergency and Urgent Services and Care Covered Worldwide"* sub-section for instructions on services that require, pre-authorization and pre-certification; and the *"Claims Review*" Section; "*Submission of Claims by Member*" sub-section for detailed instructions on how to submit a post service claim for reimbursement.

Return of Overpayments

Under the BlueCard® or the Blue Cross Blue Shield Global® Core Program, recoveries from "Host Blue" or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider audits, credit balance audits, utilization review refunds and unsolicited refunds. In some cases, the "Host Blue" will engage a third party to assist in identification of collection recovery amount. The fees of such third party may be netted against recovery.

Recovery amounts determined this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

Attachment A: Service Area

Florida Health Care Plan, Inc. Service Area -- Refer to the County below in which you work or live.

Brevard
Flagler
Seminole
St. Johns
Volusia