Summary Plan Description
of the
MDC POS Option
for the
Miami-Dade County Group Health Plan

Contract No. 00196

January 1, 2025 through December 31, 2025

TABLE OF CONTENTS

AVMED CORPORATE OFFICE
3470 NW 82nd Avenue
Doral, FL 33122

AVMED MEMBER ENGAGEMENT CENTER - ALL AREAS
1-800-68 AVMED
(1-800-682-8633)

SERVICE AREAS

Alachua	**Hendry**	Orange
Baker	Hernando	Osceola
Bradford	**Highlands***	Palm Beach
Brevard*	Hillsborough	Pasco
Broward	**Indian River***	Pinellas
Charlotte*	**Lafayette***	Polk
Citrus	Lake	**Putnam***
Clay	Lee	Sarasota
Collier*	**Leon**	Seminole
Columbia	Levy	St. Johns
DeSoto*	Manatee	St. Lucie
Dixie	**Madison***	**Sumter***
Duval	Marion	Suwannee
Flagler*	**Martin***	**Taylor***
Gilchrist	Miami-Dade	Union
Glades	**Monroe***	**Volusia***
Hamilton*	Nassau	
Hardee*	**Okeechobee***	

***PHCS providers are considered in-network for these counties.**

SERVICE AREA OFFICE

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

I. INTRODUCTION

Your employer has contracted with AvMed, Inc. (hereinafter AvMed) to arrange for the provision of Medical Services or benefits which are Medically Necessary for the diagnosis and treatment of Participants. This Point-of-Service ("POS") Plan provides benefits through a network of contracted independent providers as well as allowing you to receive benefits for Covered Services from Non-Participating Providers.

This document is a Summary Plan Description ("SPD") of the medical benefits provided to you by **Miami-Dade County** (the "County") under the **Miami-Dade County** Group Health Plan (hereinafter, the "Plan"). This SPD is made available or your reference and is subject to various legal requirements, including the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The County may designate any other third-party administrators or Claims administrators to carry out certain Plan duties and responsibilities. The County is responsible for formulating and carrying out all rules and regulations necessary to administer the Plan. To the extent not delegated to another third party, the County has the discretionary authority to make decisions regarding the interpretation or application of Plan provisions and the discretionary authority to determine the rights, eligibility, and benefits of Participants and beneficiaries under the Plan and to review Claims under the Plan. The County has delegated the discretionary authority to interpret the Plan and to make Claims determinations to AvMed.

The Plan may be amended at any time. Such amendments, for example, may (1) increase or otherwise change the cost to you for coverage, (2) change the type of benefits provided under the Plan, the conditions of participation, and any other terms of the Plan, (3) require additional contributions from Participants, or (4) terminate the Plan in whole or in part at any time.

The Plan is not intended to and does not cover or provide any Medical Services or benefits which are not Medically Necessary for the diagnosis and treatment of the Participant.

Notice of Discrimination. AvMed complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, sexual orientation, gender, gender identity, disability, or age, in its programs and activities, including in admission or access to, or treatment or employment in, its programs and activities. The following person has been designated to handle inquiries regarding AvMed's nondiscrimination policies: AvMed's Regulatory Correspondence Coordinator, P.O. Box 569008, Miami, FL 33256, by phone 1-800-882-8633 (TTY 711), or by email to regulatory.correspondence@avmed.org.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of an Out-of-Network Provider for a covered non-emergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to Out-of-Network provider charges. The basis of the payment will be determined according to the Out-of-Network reimbursement benefit. Out-of-Network Providers may bill Members for any difference in the amount. However, if a Non-Participating Provider who is a Health Professional renders services at a Participating Facility, the Plan will pay at the In-Network Benefit Level. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT. Participating Providers have agreed to accept discounted payments for Covered Services with no additional billing to you other than Coinsurance, Copayment, and Deductible amounts. You may obtain further information about the providers who have contracted with your health plan by consulting AvMed's website or contacting AvMed directly. As described in this SPD, the payment for Out of-Network Benefits will be the Maximum Allowable Payment.

II. DEFINITIONS

For further definitions, go to www.healthcare.gov/glossary to review the glossary provided as a result of the Affordable Care Act.

As used in this Summary Plan Description, each of the following terms shall have the meaning indicated:

2.01 **Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) of, a benefit resulting from the application of any Utilization Management Program, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary.

2.02 **Air Ambulance Service (Rotary Wing)** means transportation by a helicopter that is certified as an ambulance and such services and supplies as may be Medically Necessary.

2.03 **Allowed Amount** means the maximum amount upon which payment will be based for Covered Services rendered by Participating Providers and Non-Participating Providers who render services as part of a Covered Benefit. The Allowed Amount may be changed at any time without notice to you or your consent.

2.04 **Ambulatory Surgery Center** means a facility, (or, if outside Florida, applicable state law), the primary purpose of which is to provide elective surgical care, in which patient is admitted to and discharged from such facility within 24 hours, and which is not part of a hospital.

2.05 **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. Applied Behavior Analysis services shall be provided by an individual certified pursuant to Section 393.17 *Florida Statutes*, or an individual licensed under Chapter 490 or Chapter 491 *Florida Statutes*.

2.06 **Attending Physician** means the Physician primarily responsible for the care of a Member with respect to any particular injury or illness.

2.07 **Autism Spectrum Disorder** means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

2.07.01 Autistic disorder.
2.07.02 Asperger's syndrome.
2.07.03 Pervasive developmental disorder not otherwise specified.

2.08 **AvMed Network or AvMed Network Provider** means the providers and facilities that have contracted with AvMed to provide Covered Services to Members. AvMed Network Providers are also referred to as "In-Network Physician's" or "In-Network Providers". The Members' Copayment, Deductible and/or Coinsurance responsibilities are outlined in the Schedule of Benefits.

2.09 **Away From Home (AFH)** means the program, pursuant to Section IX (AWAY FROM HOME), allows Covered Dependents who temporarily reside outside of the Service Area, access to Covered Benefits from Private Healthcare Systems, Inc. (PHCS) network providers. Only dependents of

employees who live inside the Service Area are eligible. Covered Benefits provided by PHCS network providers to participants in the AFH Program will be deemed covered as if they were rendered by a Participating Provider only when such services are rendered outside the Service Area.

2.10 **Behavioral Health** is the scientific study of the emotions, behaviors and biology relating to a person's mental well-being, their ability to function in everyday life and their concept of self. Behavioral Health is the preferred term to mental health. A person struggling with his or her Behavioral Health may face stress, depression, anxiety, relationship problems, grief, addiction, ADHD or learning disabilities, mood disorders, or other psychological concerns. Counselors, therapists, life coaches, psychologists, nurse practitioners or Physicians can help manage Behavioral Health concerns with treatments such as therapy, counseling, or medication.

2.11 **Benefit Level** means:

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

2.11.02 If a participant receives Covered Services from an Out-of-Network Provider who is a Health Professional during a visit at an in-network healthcare facility, those Covered Services will be payable at the In-Network Benefit Level shown in the Schedule of Benefits, after any applicable Deductible is met.

2.11.03 For Out-of-Network Providers, For Members choosing Out-of-Network Providers for non-emergency care, the Plan will pay at the Out-of-Network Benefit Level and the Member will also be at risk for provider fees that are in excess of Allowed Amounts unless otherwise prohibited by law. In other words, a Member who chooses an Out-of-Network Provider may be responsible to pay the amount that exceeds the Maximum Allowable Payment for the particular medical service involved, in addition to the applicable Deductible and Coinsurance amounts. Also, fees that are in excess of Allowed Amounts are not a covered benefit and therefore do not apply to your Deductible or annual Out-of-Pocket Limit.

2.11.04 The Deductible may not apply to all Covered Services. See Schedule of Benefits.

2.12 **Birthing Center** is any freestanding health facility, professional office, or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

2.12.01 The **Birthing Center** must provide facilities for obstetrical delivery and short-term recovery after delivery; provided care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

2.13 **Calendar Year** means the twelve-month period beginning January 1st and ending December 31st.

2.14 **Claim** means a request for benefits under the Plan made by a Participant in accordance with the Plan's procedures for filing benefit Claims, including Pre-Service Claims and Post-Service Claims.

2.15 **Claimant** means a Participant or a Participant's authorized representative acting on behalf of the Participant. AvMed may establish procedures for determining whether an individual is authorized to act on behalf of the Participant. If the Claim is an Urgent Care or Pre-Service Claim, a Health

Professional, with knowledge of the Participant's medical condition, shall be authorized to act as the Participant's representative for notification of approvals.

2.16 **Coinsurance** means the percentage of charges for covered expenses that a Participant is required to pay under the Plan.

2.17 **Concurrent Care** means an ongoing course of treatment to be provided over a period of time or number of treatments that AvMed previously approved.

2.18 **Condition** means a disease, illness, aliment, injury, or pregnancy.

2.19 **Copayment** means the charge which the Participant is required to pay at the time certain health services are provided. The Participant is responsible for the payment of any Copayment charges directly to the provider of the health services at the time of service.

2.20 **County** means **Miami-Dade County**.

2.21 **Covered Benefits or Covered Services** means those Health Care Services provided under Section VIII (SCHEDULE OF BASIC BENEFITS), subject to the Limitations of Section X (LIMITATIONS OF BASIC BENEFITS) and the Exclusions of Section XI (EXCLUSIONS FROM BASIC BENEFITS) to which a Member is entitled under the terms of this SPD. Member's cost-sharing responsibilities for Covered Services, including any applicable Deductible, Copayments and Coinsurance amounts, are outlined in the Schedule of Benefits.

2.22 **Covered Dependent** means any eligible dependent of a Covered Employee's family who meets all applicable requirements of the Plan and is enrolled in the Plan.

2.23 **Covered Employee** means an employee of the County who meets all of the applicable requirements of the Plan and is enrolled in the Plan.

2.24 **Covered Retiree** means a former employee under the age of 65 who has retired from County services who meets all of the applicable requirements of the Plan and is enrolled in the Plan.

2.25 **Covered Retiree Dependent** mean a former employee's dependent who meets all of the applicable requirements of the Plan and is enrolled in the Plan.

2.26 **Custodial Care** means services and supplies that are furnished mainly to train or assist in the activities of daily living, such as bathing, feeding, dressing, walking, and taking oral medicines. "Custodial Care" also means services and supplies that can be safely and adequately provided by persons other than licensed Health Professionals, such as dressing changes and catheter care or that ambulatory patients customarily provide for themselves, such as ostomy care, measuring and recording urine and blood sugar levels, and administering insulin.

2.27 **Deductible** means th first payments up to a specified dollar amount, excluding Copayments, which a Member must make in the applicable Calendar Year for Covered Benefits. The Deductible applies to each Member, subject to any family Deductible listed on the Schedule of Benefits. For purposes of the Deductible, 'family' means the Covered Employee and Covered Dependents.

2.28 **Dental Care** means dental x-rays, examinations and treatment of the teeth or structures directly supporting the teeth that are customarily provided by dentists, including orthodontics, reconstructive jaw surgery, casts, splints, and services for dental malocclusion.

2.29 **Domestic Partners** means two adults who are parties to a valid domestic partnership relationship and who meet the requisites for a valid domestic partnership relationship as established by Miami-Dade County Ordinance No. 08-61 pursuant to section 11A-72 and who:

2.29.01 Are not married under Florida law, a partner to another domestic partnership relationship or a member of another civil union;

2.29.02 Are not related to the other by blood;

2.29.03 Are at least eighteen years of age;

2.29.04 Are mentally competent to consent to a contract;

2.29.05 Consider themselves to be a member of the immediate family of the other partner and to be jointly responsible for maintaining and supporting the registered domestic partnership;

2.29.06 Have filed a domestic partnership registration with the Consumer Services Department.

2.29.07 Agree to immediately notify the Consumer Services Department, in writing, if the terms of the registered domestic partnership are no longer applicable or one of the Domestic Partners wishes to terminate the domestic partnership; and

2.29.08 Reside in the same primary residence.

2.30 **Durable Medical Equipment (DME).** Durable Medical Equipment means items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of injury or illness; are appropriate for use in the home; and are not disposable. Such equipment includes but is not limited to, crutches, hospital beds, respirators, wheelchairs, and dialysis machines. The determination of whether a covered item will be paid under the DME, Orthotic or Prosthetics benefit will be based upon its classification as defined by the Center for Medicare and Medicaid Services.

2.31 **Emergency Medical Condition** means a medical Condition, including a mental health Condition, or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including sever pain) such that the absence of immediate medical attention by a prudent layperson could reasonably be expected to result in any of the following:

2.31.01 Serious jeopardy to the health of a patient, including a pregnant woman or her unborn child.

a) That there is inadequate time to effect 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

2.31.02 Serious impairment to bodily functions.

2.31.03 Serious dysfunction of any bodily organ or part.

2.31.04 Examples of Emergency Medical Conditions include, but are not limited to: heart attack, stroke, massive internal or external bleeding, fractured limbs, or severe trauma.

2.32 **Emergency Medical Services and Care** means medical screening, examination, and evaluation by a Participating Provider or a Non-Participating Provider, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Physician, to determine if an Emergency Medical Condition exists and, if it does, the care, treatment for a covered service necessary to stabilize or eliminate the Emergency Medical Condition within the service capability of the Hospital or the Independent Freestanding Emergency Department.

2.32.01 In-Area Emergency does not include elective or routine care, care of minor illness, or care that can reasonably be sought and obtained from the Participant's Primary Care Physician. The determination as to whether or not an illness or injury constitutes an

emergency shall be made by AvMed and may be made retrospectively based upon all information known at the time patient was present for treatment.

2.32.02 Out-of-Area Emergency does not include care for Conditions for which a Participant could reasonably have foreseen the need of such care before leaving the Service Area or care that could safely be delayed until prompt return to the Service Area. The determination as to whether or not an illness or injury constitutes an emergency shall be made by AvMed and may be made retrospectively based upon all information known at the time patient was present for treatment.

2.33 **Essential Health Benefits** has the meaning under Patient Protection and Affordable Care Act (PPACA) Section 1302(b) of the Federal Act and applicable regulations. The ten categories of Essential Health Benefits are:

2.33.01 ambulatory patient services;

2.33.02 emergency services;

2.33.03 hospitalization;

2.33.04 laboratory services;

2.33.05 maternity and newborn care;

2.33.06 mental health and substance abuse disorder services (including Behavioral Health treatment);

2.33.07 pediatric services (including oral and vision care);

2.33.08 prescription drugs;

2.33.09 preventive wellness services and chronic disease management; and

2.33.10 rehabilitative and habilitative services and devices.

2.34 **Exclusion** means any provision of this Plan whereby coverage for a specific service or Condition is entirely eliminated.

2.35 **Experimental and/or Investigational.** For the purpose of this Plan a medication, treatment, device, surgery or procedure that AvMed, in its discretion, determines to be Experimental and/or Investigational if any of the following applies:

2.35.01 The Food and Drug Administration (FDA) has not granted the approval for general use; or

2.35.02 There are insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

2.35.03 There is no consensus among practicing Physicians that the medication, treatment, therapy, procedure or device is safe or effective for the treatment in question or such medication, treatment, therapy, procedure or device is not the standard treatment, therapy, procedure or device utilized by practicing Physicians in treating other patients with the same or similar Condition; or

2.35.04 Such medication, treatment, procedure or device is the subject of an ongoing Phase I or Phase II clinical investigation, or 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. Notwithstanding the previous sentence,

approved clinical trials, as such term is defined by Section 2709 of the Public Health Service Act ("PHSA") will not be treated as Experimental and/or Investigational if the requirements of Section 2709 of the PHSA are satisfied.

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

2.37 **Group Health Insurance** (for purposes of Part XII.COORDINATION OF BENEFITS) means that form of health insurance covering groups of persons under a master Group Health Insurance policy issued to any one of the groups listed in Sections 627.552 (employee groups), 627.553 (debtor groups), 627.554 (labor union and association groups) and 627.5565 (additional groups), Florida Statutes.

2.37.01 The terms "amount of insurance" and "insurance" include the benefits provided under a plan of self-insurance;

2.37.02 The term "insurer" includes any person, entity or governmental unit providing a plan of self-insurance; and

2.37.03 The term "policy," "insurance policy," health insurance policy," and "Group Health Insurance policy" include plans of self-insurance providing health insurance benefits.

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

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

2.38.02 Covered Services take place in a participating non-residential setting separate from the home or facility in which the Participant lives.

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

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

2.38.05 Non-covered Habilitation Services include, but are not limited to residential based Habilitation Services, home-based Habilitation Services, institutional based Habilitation Services, personal assistance/attendant care services; errand services; transportation to and from training facilities unless provided by training facility; family education and training, family support services; prevocational services designed to

assist a Participant in acquiring basic work skills; supportive employment habilitation; respite care/camps/hotel respite, room and board; services that are purely educational in nature, personal training or life coaching; Custodial Care (care that is provided primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety and could be provided by people without professional skills or training).

2.39 **Health Care Facility**, with respect to a group health plan or group or individual health insurance coverage, in the context of non-emergency services, is each of the following:

2.39.01 A Hospital;

2.39.02 A Hospital outpatient department;

2.39.03 A Critical access Hospital; and

2.39.04 An ambulatory surgical center

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

2.41 **Health Professional** means Physicians, osteopaths, podiatrists, chiropractors, Physician assistants, nurses, social workers, pharmacists, optometrists, clinical psychologists, nutritionists, occupational therapists, physical therapists, and other professionals engaged in the delivery of health care services who are licensed and practice under an institutional license, individual practice association, or other authority consistent with state law.

2.42 **Home Health Care Services** means services that are provided for a Participant who is homebound and is unable to receive medical care on an ambulatory outpatient basis and does not require confinement in a Hospital or Other Health Care Facility. Such services include, but are not limited to, the services of professional visiting nurses or other health care personnel for services covered under the Plan.

2.43 **Hospice** means a public agency or private organization which is duly licensed by the State of Florida (or, if outside Florida, applicable state law), to provide Hospice services. Such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill Participants.

2.44 **Hospital** means a facility properly licensed Pursuant to Chapter 395, Florida Statue, (or, if outside Florida, applicable state law), that offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent. The term Hospital does not include: an Ambulatory Surgery Center; Skilled Nursing Facility, stand-alone Birthing Center, convalescent, rest or nursing home, or facility which primarily provides custodial, educational or rehabilitative therapies.

2.44.01 If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Associate, 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 score of Covered Services. It only expands the setting where Covered Services can be performed for coverage purposes.

2.45 **Hospital-owned or affiliated** means under common ownership, licensure of control of a Hospital. As may be noted in your Schedule of Benefit and Coverage, the cost-sharing for some services can vary depending on whether or not they are obtained at a Hospital-owned or Hospital-affiliated facility. See also Independent Facility.

2.46 **Hospital Services** (except as expressly limited or excluded by the Plan) means those services for registered bed patients which are:

2.46.01 Generally and customarily provided by acute care general Hospitals within the Service Area;

2.46.02 Performed, prescribed, or directed by Health Professionals; and

2.46.03 Medically Necessary for Conditions which cannot be adequately treated in Other Health Care Facilities or with Home Health Care Services or on an ambulatory basis.

2.47 **Hospitalist/Admitting Panelist** means a Physician who specializes in treating inpatients and who may coordinate a Participant's health care when the Participant has been admitted for a Medically Necessary procedure or treatment at a Hospital.

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

2.49 **Independent Freestanding Emergency Department** means a Health Care Facility (not limited to those described in the definition of Health Care Facility with respect to non-emergency services) that:

2.49.01 Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

2.49.02 Provides any emergency services as described in 2.27 Emergency Medical Services and Care.

2.50 **Injectable Medication** means a medication that has been approved by the Food and Drug Administration (FDA) for administration by one or more of the following routes: intracavernous, intramuscular, intraocular, intrathecal, intravenous or subcutaneous injection, or intravenous infusion. Prior Authorization may be required for Injectable Medications.

2.51 **In-Network Physician or In-Network Provider** means any Health Professional within the Service Area with whom is either under contract with the AvMed Network or with whom AvMed has established arrangements for providing these services as in-network.

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

2.53 **Limitation** means any provision other than an Exclusion which restricts coverage under the Plan.

2.54 **Maximum Allowable Payment** means the maximum amount that the Plan will pay for any covered service rendered by a Non-Participating Provider or supplier of services, medications or supplies. The Maximum Allowable Payment may be changed at any time by AvMed without notice to you or your consent. You may obtain an estimate of the Maximum Allowable Payment for services from Out-of-Network Providers by contacting AvMed's Member Engagement Center at the telephone number on page 2 cover of this SPD, or on your AvMed Identification Card. The fact that we may provide you with such information does not mean, and will not be construed to mean,

that the service is a Covered Benefit. All terms and conditions included in your SPD apply. Please refer to Section 6.03 Additional Expenses You Must Pay.

2.55 **Medically Necessary** means the use of any appropriate medical treatment, service, equipment, and/or supply as provided by a Hospital, Skilled Nursing Facility, Physician, or other provider that AvMed, in its discretion, determines is necessary for the diagnosis, care, and/or treatment of a Participant's illness or injury, and which is:

2.55.01 Consistent with the symptom, diagnosis, and treatment of the Participant's Condition;

2.55.02 The most appropriate level of supply and/or service for the diagnosis and treatment of the Participant's Condition;

2.55.03 In accordance with standards of acceptable community practice;

2.55.04 Not primarily intended for the personal comfort or convenience of the Participant, the Participant's family, the Physician, or other Health Care Provider;

2.55.05 Approved by the appropriate medical body or health care specialty involved as effective, appropriate, and essential for the care and treatment of the Participant's Condition;

2.55.06 Prescribed, directed, authorized, and/or rendered by a provider, except in the case of an emergency; and

2.55.07 Not Experimental and/or Investigational.

2.56 **Medical Office** means any outpatient facility or Physician's office utilized by a Health Professionals.

2.57 **Medical Services** (except as limited or excluded by the Plan) means those professional services of Physicians and other Health Professionals including medical, surgical, diagnostic, therapeutic, and preventive services which are:

2.57.01 Generally and customarily provided in the Service Area;

2.57.02 Performed, prescribed, or directed by any Health Professional or group of Health Professionals or Hospital, Medical Office, or Other Health Care Facility; and

2.57.03 Medically Necessary (except for preventive services as stated herein) for the diagnosis and treatment of injury or illness.

2.58 **Member** means any Covered Employee, Covered Retiree, or Covered Dependent, as described in Part III, Sections 3.01 and 3.02, of this Summary Plan Description.

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

2.60 **Morbid Obesity** (clinically severe obesity) means a body mass index (BMI), as determined by a Participating Provider as of the date of service, of:

2.60.01 40 kilograms or greater per meter squared (kg/m2); or

2.60.02 35 kilograms or greater per meter squared (kg/m2) with an associated comorbid Condition such as hypertension, type II diabetes, life-threatening cardiopulmonary Conditions; or joint disease that is treatable; if not for obesity.

2.61 **Non-Participating Emergency Facility** means an emergency department of a hospital, or an Independent Freestanding Emergency Department (or a hospital, with respect to services that are

included as emergency services), that does not have a contractual relationship directly or indirectly with a group health plan or a group or individual health insurance coverage offered by a health insurance issuer, with respect to eh furnishing of an item of service under the plan or coverage, respectively.

2.62 **Non-Participating Provider** means any Physician, Other Health Care Facility, or Other Health Care Provider with whom AvMed has neither made arrangements nor contracted to render the professional health services set forth herein.

2.63 **Other Health Care Facility(ies) or Other Health Care Provider** means any licensed facility, other than acute care Hospitals and those facilities providing services to ventilator dependent patients, providing inpatient services such as skilled nursing care or Rehabilitation Services.

2.64 **Out-of-Network Provider** means any Health Care Provider with whom AvMed has neither contracted nor has made established arrangements for providing Covered Benefits or Covered Services as an In-Network Provider.

2.65 **Outpatient Rehabilitation Facility** means an entity, which renders, through providers properly licensed pursuant to Florida law or if applicable, equivalent or similar laws of another state, outpatient physical, speech, occupational, and cardiac rehabilitation therapy for the primary purpose of restoring or improving bodily function impaired or eliminated by a Condition. The term Outpatient Rehabilitation Facility, as used herein, shall not include a Hospital, including a general acute care Hospital, or any separately organized unity of a Hospital which provides comprehensive medical rehabilitation inpatient services, or rehabilitation outpatient services, including, but not limited to, a Class III "specialty rehabilitation hospital" as described in Chapter 59A, *Florida Administrative Code.*

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

2.67 **Participant** means any Covered Employee, Covered Retiree, or Covered Dependent, as described in Part III, Sections 3.01 and 3.02, of this Summary Plan Description.

2.68 **Participating Health Care Facility** means any Health Care Facility described in this section that has a contractual relationship directly or indirectly with a group health plan or health insurance issuer offering group or individual health insurance coverage setting forth the terms and conditions on which a relevant item or service is provided to a participant, beneficiary, or enrollee under the plan or coverage, respectively. A single case agreement between a Health Care Facility and a plan or issuer that is used to address unique situations in which a participant, beneficiary, or enrollee requires services that typically occur Out-of-Network constitutes a contractual relationship for purposes of this definition and is limited to the parties to the agreement.

2.69 **Participating Provider** means any Physician, Other Health Care Facility, or Other Health Care Provider with whom AvMed has made a contractual relationship directly or indirectly to render the professional health services set forth herein, including those providers within the AvMed Extended Network. Participating Providers are also referred to as "In-Network Physicians" or "In-Network Providers".

2.70 **Physician or Health Care Provider** means any Physician or Other Health Care Provider who is acting within the scope of practice of that provider's license under Chapter 458 (Physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes* with whom AvMed has made arrangements or contracted with to render professional health services, as set forth herein.

"**Attending Physician**" means the Physician primarily responsible for the care of a Participant with respect to any particular injury or illness.

2.71 **Plan** means the **Miami-Dade County** Group Health Plan sponsored by the County to provide covered Medical Services to Participants.

2.72 **Plan Administrator** means **Miami-Dade County**.

2.73 **Post-Service Claim** means any Claim for benefits under the Plan that is not a Pre-Service Claim.

2.74 **Pre-Service Claim** means any Claim for benefits under the Plan with respect to which, in whole or in part, a Participant must obtain authorization from AvMed in advance of such services being provided to or received by the Participant.

2.75 **Primary Care Physician** means a Physician engaged in family medicine, pediatrics, or internal medicine obstetrics/gynecology, osteopathy, or any specialty Physician.

2.75.01 AvMed generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating care provider, contact the Plan Administrator, or visit www.avmed.org/mdc. For children, you may designate a pediatrician as a primary care provider.

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

2.77 **Private Duty Nursing** means services provided by registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular Member by arrangements between the Member and the private-duty nurse or attendant. Such persons are engaged or paid by an individual Member or by someone acting on their behalf, including a Hospital that initially incurs the costs and looks to the Member for reimbursement for such services.

2.78 **Private Healthcare Systems, Inc. (PHCS)** serves as a primary network for covered medical care in the expanded counties as noted with an asterisk (*) on Page 2. For Covered Employees and their Covered Dependents who reside outside of the Service Area, PHCS is their designated network. The PHCS network may also be used as the primary network for Covered Dependents who temporarily reside outside of the AvMed Service Area and qualify for the Away From Home program.

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

2.80 **Relevant Document** means any documentation that:

2.80.01 Was relied upon in making the benefit determination;

2.80.02 Was submitted, considered or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the determination.

2.80.03 Demonstrated compliance with the administrative process; and

2.80.04 Constitutes a statement of policy or guidance with respect to the Plan concerning the Adverse Benefit Determination for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the Adverse Benefit Determination.

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

2.82 **Residential Treatment** is a (24-hour) intensive structured and supervised treatment program providing an inpatient level of care but in a non-Hospital environment and is utilized for those disorders that cannot be affectively treated in an outpatient or Partial Hospitalization environment.

2.83 **Service Area** means those counties in the State of Florida where AvMed has been approved to conduct business by the Florida Department of Financial Services.

2.84 **Specialty Health Care Professional** means a Health Professional other than the Participant's chosen Primary Care Physician.

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

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

2.87 **Urgent Care Claim** means any Claim for medical care or treatment that could seriously jeopardize the Participant's life or health or the Participant's ability to regain maximum function or, in the opinion of a Physician with knowledge of the Participant's medical Condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment requested. Generally, the determination of whether a Claim is an Urgent Care Claim shall be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician with knowledge of the Participant's medical Condition determines that the Claim is an Urgent Care Claim, it shall be deemed as such.

2.88 **Urgent Medical Condition** means a medical Condition manifesting itself by acute symptoms that are of lesser severity than that recognized for an Emergency Medical Condition, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the illness or injury to place the health or safety of the Member or another individual in serious jeopardy, in the absence of medical treatment within 24 hours. Examples of Urgent Medical Conditions include, but are not limited to are: high fever, dizziness, animal bites, sprains, severe pain, respiratory ailments and infectious illnesses.

2.89 **Urgent Medical Services and Care** means medical screening, examination and evaluation in an ambulatory setting outside of a Hospital emergency facility, including an Urgent Care Center, Retail Clinic or PCP office after-hours, on a walk-in basis and usually without a scheduled appointment; and the Covered Services for those Conditions which, although no life-threatening, could result in serious injury or disability if left untreated.

2.90 **Urgent Care/Immediate Care** means medical screening, examination, and evaluation received in an Urgent Care Center or Immediate Care Center or rendered in your Primary Care Physician's office after-hours and the Covered Services for those Conditions which, although not life-threatening, could result in serious injury or disability if left untreated.

2.91 **Utilization Management Program** means those procedures adopted by AvMed to assure that the supplies and services provided to Participants are Medically Necessary. These include, but are not limited to: (1) pre-authorization for all inpatient services, observation services, residential treatment, outpatient surgery, intensive outpatient programs, complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging), non-emergency ambulance, dialysis services, transplant services, select medications including injectables; (2) concurrent review of all patients hospitalized in acute care, psychiatric, rehabilitation, and skilled nursing facilities, including on-site review when appropriate; (3) case management for all inpatients who need continued care in an alternative setting (such as homecare or a skilled nursing facility) and for outpatients when deemed appropriate. The program may also advocate alternative cost-effective settings for the delivery of prescribed care and may identify other options for non-covered health care needs.

2.92 **Ventilator Dependent Care Unit** means any facility which provides services to ventilator dependent patients other than an acute care Hospital setting, including all types of facilities known as sub-acute care units, Ventilator Dependent Care Units, alternative care units, sub-acute care centers, and all other like facilities whether maintained in a free standing facility or maintained in a Hospital or skilled nursing facility setting. Coverage is limited to 100 days lifetime maximum.

2.93 **Virtual Visits**

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

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

III. ELIGIBILITY

3.01 To be eligible to enroll as a Participant, a person must be: Any full-time County employee, or any part-time employee who is scheduled to work at least sixty (60) hours bi-weekly, unless otherwise defined by the County's eligibility guidelines.

3.02 Employees under age 65 who retire from County service may continue coverage for themselves and their Covered Dependents until age 65 with remittance of the required premium to the County. The dependents of deceased retirees or of retirees attaining Medicare eligibility may be extended COBRA benefits through the group health plan by remitting the appropriate premiums pursuant to Section 7.03 COBRA Continuation Coverage.

3.03 To be eligible to enroll as a Covered Dependent, a person must be:

3.03.01 the spouse or Domestic Partner of the Covered Employee; the spouse or Domestic Partner of a Covered Retiree if enrolled while an active employee. A new spouse or Domestic Partner must be enrolled within forty-five (45) days after the marriage or registration of domestic partnership. Coverage is effective on the first day of the month following receipt of the application. A spouse or Domestic Partner may request to enroll following the loss of other coverage in accordance with Section 4.03.

3.03.02 a child of the Covered Employee, a child of a Domestic Partner or a child of a Covered Dependent of the Covered Employee, provided that the following conditions apply:

a) The child is the natural child, stepchild or foster child of the Covered Employee or a child of a Domestic Partner; a legally adopted child in the custody of the Covered Employee from the earlier of date of adoption or placement in the home (written evidence of adoption must be furnished to AvMed upon request); a child for whom the Covered Employee is permanent legal guardian; or a newborn child of a Covered Dependent other than the spouse of the Covered Employee (such coverage terminates 18 months after the birth of the newborn child). In the event an eligible Dependent child does not reside with the Subscriber, coverage will be extended where the Subscriber is obligated to provide medical care by Qualified Medical child Support Order (QMCSO). You (or your beneficiaries) may obtain, without charge, copies of the Plan's procedures governing QMCSOs and a sample QMCSO by contacting the Plan Administrator.

b) The child is under the age of 26;

c) In the case of a newborn child, the County must be notified in writing, and such notice shall not be later than sixty (60) days after the birth. Changes to add a new dependent become effective the first day of the month following receipt of a timely request with the exception of birth, adoption or placement for adoption which become effective as of birth or the earlier of: 1) adoption or 2) placement for adoption. If the Change in Status (CIS) Form is received by the Benefits Division within the first 31 days from birth, the premium is waived for the first (31) days. If the CIS Form is received after the first (31) days, but within sixty (60) days after the birth, the new premium will be charged retroactive to the date of birth. The same applies when adding an adopted child or child placed for adoption. The premium is waived if the CIS Form is received within the first 31 days from the earlier of: 1) adoption or 2) placement for adoption. If the CIS Form is received after the first 31 days, but within (60) days of the event, the new premium will be charged retroactive to the earlier of: 1) adoption or 2) placement for adoption. If notice is not provided within sixty (60) days of the birth, the child may not be enrolled until the next open enrollment period of the County. Payroll changes to add a newborn are processed in accordance with Florida Statute 641.31(a). Payroll changes to delete a dependent for other than those events specified in this paragraph, become effective the first day of the pay period following receipt of notice.

d) All services applicable for Covered Dependent children under the Plan shall be provided to an enrolled newborn child of the Covered Employee or to the enrolled newborn child of a Covered Dependent of the Covered Employee or to the newborn adopted child of the Covered Employee provided that a written agreement to adopt such child has been entered into (prior to the birth of the child) from the moment of birth. In the case of the newborn adopted child, however, coverage shall not be effective if the child is not ultimately placed in the Covered Employee's residence in compliance with Florida law.

e) Coverage for the newborn child of a Covered Dependent of the Covered Employee (other than the spouse of the Covered Employee) shall terminate eighteen (18) months after the birth of the newborn child.

f) AvMed will verify eligibility of dependents with different last names during open enrollment. AvMed reserves the right, on behalf of the Plan, to audit dependent eligibility at any time.

3.03.03 The child of a Covered Employee, a covered Domestic Partner or a Covered Retiree between the ages of 26 to 30, if the child meets the following requirements:

a) Is unmarried and does not have a dependent of his or her own;

b) Is a resident of Florida or a Full-time or Part-time Student; and

c) Is not provided coverage as a named Participant, insured, enrollee or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

d) The child is not eligible to be covered unless the child was continuously covered by creditable coverage without a gap in coverage of more than sixty three (63) days.

e) Extended coverage will be provided if all of the above qualifications are met until the end of the calendar year in which the child reaches age 30.

f) AvMed will verify eligibility on an annual basis and Covered Employee agrees to provide documentation of dependent eligibility upon request.

3.04 No person is eligible to enroll hereunder who has had his coverage previously terminated under Part VII, "Termination for Cause," except with the written approval of the County.

3.05 Attainment of the limiting age by a dependent child shall not operate to exclude from or terminate the coverage of such child nor shall coverage prevent the enrollment of a child while such child is and continues to be both:

3.05.01 incapable of self-sustaining employment by reason of intellectual or physical disabilities; and

3.05.02 chiefly dependent upon the Covered Employee for support and maintenance, provided proof of such incapacity and dependency is furnished to AvMed within thirty-one (31) days of the child's attainment of the limiting age and subsequently as may be required, but not more frequently than annually after the two-year period following the child's attainment of the limiting age. If the child is eligible under a plan that the employee is covered under prior to joining the County's Plan, that with proof of prior creditable coverage demonstrating the child was covered under these circumstances prior to age 26 or the prior plan's limiting age, and then the Participant joins the County's Plan, the Plan will accept the child with disabilities.

3.06 If the child of a Covered Employee, a child of a Domestic Partner or a child of a Covered Dependent of the Covered Employee was enrolled in the Plan on the basis of being a Full-Time or Part-Time Student at a postsecondary educational institution immediately before the first day of a Medically Necessary leave of absence, the Plan will not terminate the coverage of such child before the earlier of (1) on year after the first day of the Medically Necessary leave of absence, or (2) the date on which such coverage would otherwise terminate under the terms of the Plan. A "Medically Necessary leave of absence" is a leave of absence (or any other change in enrollment), from a postsecondary educational institution that (1) begins while the child is suffering from a severe illness or injury, (2) is Medically Necessary, and (3) causes the child to lose student status under the terms of the Plan. Certification by the child's Attending Physician must be submitted to the Plan stating that the child is suffering from a severe illness or injury and that the leave of absence

or other change of enrollment is Medically Necessary. A child whose benefits are continued under this provision is entitled to the same benefits as if (during the Medically Necessary leave of absence) the child continued to be a covered Full-Time or Part-Time Student at the institution of higher education and was not on a Medically Necessary leave of absence.

3.07 The Plan Administrator has the right to request proof of marriage, birth, financial dependency (including proof of the Covered Employee declaring the Covered Dependent child as an income tax deduction), and other written proof deemed necessary to confirm eligibility requirements are met. Failure to provide documentation within 30 days of the request will be treated as though eligibility is not met.

IV. ENROLLMENT

4.01 Prior to the effective date of the Plan and at a proper time prior to each anniversary thereof, the County may provide an annual open enrollment period, in which any eligible active employee on behalf of himself and his dependents may elect to enroll in the Plan. A Covered Retiree may not add a dependent, other than a newly eligible dependent, when first eligible.

4.02 Eligible employees and dependents who initially meet the requirements of Part III must enroll within sixty (60) days after becoming eligible. Otherwise, the eligible employees and dependents may not enroll until the next open enrollment period of the County or a Special Enrollment event.

4.03 Change in Status and Special Enrollment Provisions.

An eligible employee or dependent may request to enroll in the Plan outside of the initial enrollment period and annual open enrollment periods if that individual loses other coverage or acquires a new dependent as outlined below:

4.03.01 If the eligible employee or dependent declined coverage under the Plan when it was first offered because of other group health plan coverage or insurance coverage and such coverage has terminated as a result of:

a) Exhaustion of COBRA continuation coverage;

b) Termination of employment or reduction in hours of employment;

c) Termination of employer contributions:

d) Divorce, annulment or termination of domestic partnership;

e) Change in dependent status;

f) Death of an employee;

g) Change in legal custody or legal guardianship;

h) Relocation out of a Service Area; or

i) The eligible employee or dependent completes and submits an Enrollment or Status Change request within 45 days of the termination of other coverage and provides proof of continuous coverage under the other plan.

4.03.02 If a Participant acquires a new dependent as a result of:

a) Marriage;

b) Birth;

c) Adoption or placement for adoption;

d) Domestic Partner Registration; or

e) The eligible Participant or dependent completes and submits an Enrollment or Status Change request within 45 days of the date the dependent becomes eligible (or within 60 days as required for newborns). If an employee is eligible but not enrolled, the employee will also be required to enroll at this time.

4.03.03 Termination resulting from failure to pay premiums on a timely basis or termination of coverage for cause (due to fraud, intentional misrepresentation, etc.) will not provide a special enrollment period.

4.03.04 **CHIPRA**. Employees and their dependents who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within sixty (60) days following:

a) Termination of coverage under Medicaid or Children's Health Insurance Plan (CHIP) due to loss of eligibility; or

b) Determination of eligibility for premium assistance under Medicaid or CHIP.

c) The employee or dependent must complete and submit an Enrollment or Status Change request within sixty (60) days of the date of the loss of Medicaid or CHIP coverage, and within sixty (60) days of the determination of eligibility for premium assistance under Medicaid or CHIP. If an employee is eligible but not enrolled, the employee will also be required to enroll at this time in order to cover an eligible dependent.

4.04 The eligibility requirements set forth in Part III. ELIGIBILITY shall at all times control and no coverage contrary thereto shall be effective. Coverage shall not be implied due to clerical or administrative errors if such coverage would be contrary to Part III. ELIGIBILITY.

V. EFFECTIVE DATE OF COVERAGE

Subject to the payment of applicable monthly administrative fees, coverage under this Plan shall become effective on the following dates:

5.01 Eligible employees and dependents who enroll during the open enrollment period will become Participants as of the effective date of this Plan or subsequent anniversary thereof.

5.02 If a Covered Employee, , spouse, Domestic Partner or Covered Retiree acquires an eligible dependent through birth, adoption, placement for adoption or marriage, such dependent shall be covered under the Plan if, within forty-five (45) days (or as otherwise provided for newborns in Part III. ELIGIBILITY) of acquiring the new dependent, you complete and submit a status change form on behalf of such dependent. If received by the Plan within the forty-five (45) day time period (or sixty (60) days as permitted for newborns), the enrollment for such dependent shall become effective on the date of the birth, or the earlier of: 1) adoption or 2) placement for adoption, or 3) for marriage, the first day of the month following receipt of the status change form**.** During this period, you and your eligible spouse may also enroll for medical coverage under the Plan, if not already covered. However, if an enrollment is not received by the Plan within the required timeframe, you and your eligible dependents will be required to wait until the next open enrollment period to apply for coverage, absent eligibility for a second special enrollment period. Qualifying changes to add dependents who are losing coverage that are received prior to the end of that coverage will be effective the day following the end of the coverage.

5.03 If you or your dependents originally declined medical coverage under the Plan due to other health coverage, and that coverage is subsequently terminated as a result of either a loss of eligibility for such coverage or the termination of any employer contributions for such coverage, or termination of that plan, you and your eligible dependents will be eligible to enroll in the Plan. To enroll, you

must submit a properly completed enrollment form to the County within forty-five (45) days of the loss of such other coverage or termination of employer contributions. The effective date of any coverage provided under the Plan will be the first day of the month following the date you enroll. If you fail to enroll within forty-five (45) days after the loss of other coverage, you must wait until the next open enrollment period to apply for coverage, absent eligibility for a second special enrollment period.

VI. MONTHLY PAYMENTS AND COPAYMENTS

6.01 Annual Out-of-Pocket Maximum (as described in your Schedule of Benefits). The Deductible, as well as any Coinsurance and Copayments you pay for Covered Benefits received during any Calendar Year are accumulated toward the annual out-of-pocket maximum. Once you meet your individual or family annual out-of-pocket maximum in any Calendar year, the Plan will pay 100% of the allowable charges for all Covered Services for the remainder of that Calendar Year. It is the responsibility of the Member to retain receipts and to notify and document to the satisfaction of the Plan when the annual out-of-pocket maximum have been reached.

6.02 **Additional Expenses You Must Pay**. Expenses that do not count toward the annual maximum out-of-pocket expense limit are:

6.02.1 (i) expenses related to charges for non-Covered Services including charges exceeding the Maximum Allowable Payment;

6.02.2 (ii) additional charges incurred for failure to pre-authorize a service requiring Prior Authorization;

6.02.3 (iii) expenses that relate to services that exceed any specific treatment Limitations noted in the Schedule of Benefits, and

6.02.4 (iv) Brand Additional Charges for prescription medications;

6.02.5 Charges in excess of the Maximum Allowable Payment for Covered Services rendered by Out-of-Network Provider for non-emergency services who have not agreed to accept our Maximum Allowable Payment as payment in full, when permitted by law. Except in the case of emergencies, a Member who proactively elects to receive services from an Out-of-Network Provider may be responsible to pay an amount that exceeds the Maximum Allowable Payment for the Health Care Services involved, in addition to the applicable Deductible and Coinsurance amounts. Also, fees that are in excess of allowable charges are not a Covered Benefit and therefore do not apply to your Deductible or annual out-of-pocket expense. In addition, if you receive services from an Out-of-Network Provider you are responsible for filing the Claim, and that payment will be made directly to you. If the provider files the Claim for you, payment will be made directly to the provider. WE RECOMMEND THAT, PRIOR TO CHOOSING AN OUT-OF-NETWORK PROVIDER FOR PARTICULAR COVERED SERVICES, YOU CONTACT MEMBER ENGAGMENT AT THE TELEPHONE NUMBER ON PAGE iii OF THIS SPD OR ON YOUR AVMED IDENTIFICATION CARD TO OBTAIN AN ESTIMATE OF THE MAXIMUM ALLOWABLE PAYMENT SO THAT YOU ARE AWARE OF YOUR FINANICAL RESPONSIBILITIES WITH REGARD TO THOSE SERVICES.

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

6.04 **Copayment and Coinsurance Requirements.** Covered Services rendered by certain Health Care Providers will be subject to a Copayment or Coinsurance requirement. This is the fixed dollar amount (Copayment) or percentage (Coinsurance) of the Allowed Amount or Maximum Allowable. After satisfying the Deductible, the Member must pay any applicable Copayments or Coinsurance for Covered Benefits. Covered Benefits to which the Deductible applies are shown in the Schedule of Benefits.

6.05 In the event of the retroactive termination of a Member, neither the Plan nor AvMed shall be responsible for medical expenses incurred by the Plan in providing benefits to the Member under the terms of the Plan after the effective date of termination.

VII. TERMINATION OF PARTICIPATION

7.01 **Reasons for Termination:**

7.01.01 **Loss of Eligibility:**

a) Upon a loss of the Covered Employee's or Covered Dependent's eligibility, as defined in Part III. ELIGIBILITY, coverage shall automatically terminate on the last day of the pay period for which the applicable payroll deductions are made, if any, and during which the employee or dependent was eligible for coverage.

b) Upon a loss of the Covered Employee's eligibility, coverage for all dependents shall automatically terminate on the last day of the pay period for which the applicable payroll deductions are made. However, if the loss of eligibility results from a divorce or termination of a domestic partnership, such coverage shall terminate on the date of the divorce or dissolution of the domestic partnership.

c) Upon a loss of the Covered Dependent child's eligibility due to attainment of the limiting age, as defined in Part III. ELIGIBILITY, coverage shall automatically terminate at the end of the calendar year in which the dependent reaches the limiting age.

7.01.02 **Failure to Pay Fees.** Upon failure of the County to make payment of the monthly administrative fee within thirty (30) days following the due date specified by AvMed, benefits under shall terminate for all Participants for whom such payment has not been received at 12:00 a.m. (midnight) on the last day of the month for which the monthly administrative fee was paid.

7.01.03 **Termination of Participation for Cause.** The Plan may terminate or cease to provide services to any Participant immediately upon written notice for the following reasons which lead to a loss of eligibility of the Participant:

a) fraud, material misrepresentation, or omission in applying for benefits, or coverage under the Plan;

b) misuse of the Identification Card furnished by AvMed to the Participant;

c) furnishing to the Plan incorrect or incomplete information for the purpose of obtaining coverage or benefits under the Plan;

d) behavior which is disruptive, unruly, abusive, or uncooperative to the extent that the Participant's continuing coverage under the Plan seriously impairs AvMed's ability to administer the Plan or to arrange for the delivery of health care services to the Participant or other Participants after AvMed and the County have attempted to resolve the Participant's problem.

7.01.04 At the effective date of such termination, administrative fees received by AvMed, on account of such termination shall be refunded on a pro rata basis, and AvMed shall have no further liability or responsibility for the Participant(s) under the Plan.

7.01.05 In the event of the retroactive termination of an individual Participant, the Plan shall not be responsible for medical expenses under the terms of the Plan after the effective date of termination.

7.02 **Notification Requirements:**

7.02.01 **Loss of Eligibility of Covered Employee**. It is the responsibility of the County to notify AvMed in writing regarding any Covered Employee and/or Covered Dependent who becomes ineligible to participate in the Plan. The County shall be liable for claims incurred by Covered Employees or Covered Dependents resulting from failure of the Employer to provide such timely notification.

7.02.02 **Loss of Eligibility of Dependent.** When a dependent becomes ineligible for dependent coverage due to age, student status, etc., the Covered Employee is required to notify the County in writing within forty-five (45) days of the dependent becoming ineligible.

7.03 **COBRA Continuation Coverage.** A federal law (the Consolidated Omnibus Budget Reconciliation Act, commonly known as ("COBRA") requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. This section of the SPD is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this section carefully.

7.03.01 **Eligibility.** You or your Covered Dependents will become eligible for continuation coverage under (COBRA), after any of the following qualifying events result in the loss of plan coverage:

a) loss of benefits due to a reduction in your hours of employment;

b) termination of your employment, including retirement but excluding termination for gross misconduct;

c) termination of employment following leave under the Family and Medical Leave Act of 1996 ("FMLA"), in which case the qualifying event will occur on the earlier of the date you indicated you were not returning to work or the last day of the FMLA leave; or

d) you or a dependent first become entitled to Medicare or covered under another group health plan prior to your loss of coverage due to termination of employment or reduction in hours.

7.03.02 In addition, your Covered Dependents will become eligible for COBRA continuation coverage after any of the following qualifying events occur to cause a loss of plan coverage:

a) your death;

b) your divorce, legal separation or termination of domestic partnership;

c) you first become entitled to Medicare after your loss of coverage due to termination of employment or reduction in hours; or

d) your dependent child no longer qualifies as a dependent under the plan.

e) A child who is born to or placed for adoption with a covered former employee during the continuation coverage period has the same continuation coverage rights as a dependent child described above.

7.03.03 **Notification.** If a qualifying event other than divorce, legal separation, loss of dependent status or entitlement to Medicare occurs, the Plan Administrator will be notified of the qualifying event by your employer and will send you an election form. To continue plan coverage, you must return the election form within 60 days from the later of the date you received the form, or the date your coverage ends due to a qualifying event.

a) If divorce, legal separation, loss of dependent status or entitlement to Medicare under the Plan occurs, you or your Covered Dependent must notify the Plan Administrator that a qualifying event has occurred. In order to protect your COBRA continuation rights this notification must be received by the COBRA plan administrator within 60 days after the later of the date of such event, or the date you or your eligible dependent would lose coverage on account of such event. Failure to promptly notify the Plan Administrator of these events will result in loss of the right to continue coverage for you and your dependents.

b) After receiving this notice, the COBRA plan administrator will send you an election form within 14 days. If you or your Covered Dependents wish to elect continuation coverage, the election form must be returned to the COBRA plan administrator within 60 days from the later of the date you received the form, or the date your coverage ends due to the qualifying event.

7.03.04 **Cost.** If you elect to continue coverage, you must pay the entire cost of coverage (the employer's contribution and the active employee portion of the contribution), plus a 2% administrative fee for the duration of COBRA continuation coverage.

a) If you or your dependent is Social Security disabled (Social Security disability status must occur as defined by Title II or Title XVI of the Social Security Act), you may elect to continue coverage for the disabled person only or for some or all of COBRA eligible family Participants for up to 29 months if your employment is terminated or your hours are reduced. You must pay 102% of the cost of coverage for the first 18 months of COBRA continuation coverage and 150% of the cost of coverage for the 19th through the 29th months of coverage. The Social Security disability date must occur within the first 60 days of loss of coverage due to your termination of employment or reduction in hours.

b) For COBRA coverage to remain in effect, payment must be received by the plan administrator by the first day of the month for which the premium is due. (Your first payment is due no later than 45 days after your election to continue coverage, and it must cover the period of time back to the first day of your COBRA continuation coverage.)

7.03.05 **Duration.** COBRA Continuation Coverage can be continued for up to:

a) 18 months if coverage ended due to a reduction in your work hours or termination of your employment and you or one of your Covered Dependent(s) is not Social Security disabled within 60 days of the date you lose coverage due to termination of employment or reduction in hours, the Medicare entitled person may elect up to 18 months of COBRA. If you are that Medicare entitled person, your dependents may elect COBRA for the longer of 36 months from your prior Medicare entitlement date, or 18 months from the date of your termination or reduction in hours.

b) 36 months for Covered Dependents, if your dependents lose eligibility for medical coverage due to your death, divorce, legal separation or termination of domestic partnership, your entitlement to Medicare after your termination or reduction in hours, or your dependent child ceasing to qualify as a dependent under the plan

c) 29 months if you lose coverage due to a termination of employment or reduction in hours and you or a dependent is disabled, as defined by Title II or Title XVI of the Social Security Act, within 60 days of the original qualifying event. In this case, you may continue coverage for an additional 11 months after the original 18 month period either for the disabled person only or for one or all of your Covered Dependents.

d) To be eligible for extended coverage due to Social Security disability, you must notify the COBRA plan administrator of the disability within 60 days after the latest of: 1) the date of the Social Security Administration's disability determination; 2) the date of the Covered Employee's termination of employment or reduction in hours; and 3) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination or reduction. Your Notice of Disability must also be provided before the end of the initial 18 months of COBRA continuation coverage. If the disabled individual should no longer be considered to be disabled by the Social Security Administration, you must notify the COBRA plan administrator within 30 days following the end of the disability. Coverage that has exceeded the original 18 month continuation period will end when the individual is no longer Social Security disabled.

e) If more than one qualifying event occurs, no more than 36 months total of COBRA continuation coverage will be available. The COBRA beneficiary must experience the second qualifying event during the first 18 months of COBRA continuation and must provide notice to the COBRA plan administrator within the required time period. COBRA continuation coverage will end sooner if the Plan terminates and the employer does not provide replacement medical coverage, or if a person covered under COBRA:

1) first becomes covered under another group health plan after the loss of coverage due to your termination or reduction in hours; this plan will be secondary for all eligible health care expenses, provided contributions for COBRA coverage continue to be paid. Coverage may only continue for the remainder of the original COBRA period;

2) fails to make required contributions when due;

3) first becomes entitled to Medicare benefits after the initial COBRA qualifying event; or

4) is extending the 18 month coverage period because of disability and is no longer disabled as defined by the Social Security Act.

7.04 **Continuation Coverage During Leaves of Absence.**

7.04.01 **Family and Medical Leaves of Absence ("FMLA").** Under the Family and Medical Leave Act of 1993, you may be entitled to up to a total of 12 weeks of unpaid, job-protected leave during each calendar year for the following:

a) the birth of your child, to care for your newborn child, or for placement of a child in your home for adoption or foster care;

b) to care for your spouse, child or parent with a serious health Condition; or

c) for your own serious health Condition.

7.04.02 If your FMLA leave is a paid leave, your pay will be reduced by your before-tax contributions as usual for the coverage level in effect on the date your FMLA leave begins. If your FMLA leave is unpaid, you will be required to pay your contributions directly to the employer until you return to active pay status. Your contribution for coverage will be the same as similarly situated active participants.

7.04.03 If you notify your employer that you are terminating employment during your FMLA leave, your coverage will end on the last day of the pay period in which you terminate providing premiums are paid.

7.04.04 You may not change your Plan elections during your FMLA leave unless an open enrollment occurs or you have a change in status event or a special enrollment event under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

7.05 **Military Caregiver Leave Entitlements.** FMLA leave for this purpose is called "military caregiver leave". Military caregiver leave allows a covered employee who is the spouse, son, daughter, parent or next of kin of a covered service member with a serious injury or illness to take up to a total of 26 workweeks of unpaid leave during a single 12-month period to provide care for the service member. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is receiving medical treatment, recuperation, or therapy, or is in outpatient status, or is on the temporary disability retired list for a serious injury or illness.

7.06 **Military Leaves of Absence.** If you are absent from work due to military service, you may elect to continue coverage under the Plan (including coverage for Covered Dependents) for up to 24 months from the first day of absence (or, if earlier, until the day after the date you are required to apply for or return to active employment with your employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")). Your contributions for continued coverage will be the same as for similarly situated active participants in the Plan.

7.06.01 Whether or not you continue coverage during military service, you may reinstate coverage under the Plan option you elected on your return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that you had not fully completed any required waiting period prior to the start of the military service.

7.07 **Other Leaves of Absence.** If you are absent from work while on other approved leave of absence, you may elect to continue coverage for up to 12 months (plus an additional 12 months at the discretion of the County). Such coverage will be provided with remittance of the required premium to the County.

VIII. SCHEDULE OF BASIC BENEFITS

The professional judgment of a Physician concerning the proper course of treatment of a Participant shall not be subject to modification by AvMed or its Board of Directors, Officers, or Administrators. However, this subsection is not intended to and shall not restrict any Utilization Management Program established by AvMed.

All Covered Services and benefits shall be provided in conformity with the terms of the Plan. It is the Participant's responsibility when seeking benefits under the Plan to identify himself as a Plan Participant.

Also, Participants must understand that services will not be covered if they are not Medically Necessary. Any and all decisions made by AvMed in administering the provisions of this SPD, including without

limitation, the provisions of Part VIII (SCHEDULE OF BASIC BENEFITS), Part X (LIMITATIONS OF BASIC BENEFITS), and Part XI (EXCLUSIONS), are made only to determine whether payment for any benefits will be made by the Plan. Any and all decisions that pertain to the medical need for, or desirability of the provision or non-provision of Medical Services or benefits, including without limitation, the most appropriate level of such Medical Services or benefits, must be made solely by the Participant and his Physician, in accordance with the normal patient/Physician relationship for purposes of determining what is in the best interest of the Participant. AvMed does not have the right of control over the medical decisions made by the Participant's Physician or Health Care Providers. The ordering of a service by a Physician, whether Participating or Non-Participating, does not in itself make such service Medically Necessary.

Point of Service medical benefits provide coverage for care in-network and Out-of-Network. To receive Point-of-Service medical benefits, you and your dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

Benefit Payment Levels

This Point-of-Service Plan has several special features that can influence how much you pay out-of-pocket for medical care. Your choice of a Health Professional may result in lower or higher costs and you will be required to follow certain procedures to avoid additional costs. Your choice of a Health Professional and wise use of these benefits can save you money.

This POS Plan creates two benefit payment levels; one for services provided by Participating Providers and a second for services provided by Non-Participating Providers. The Benefit Level this Group Plan will pay depends on the Health Professional you select to provide covered health care services:

1. If the Health Professional and/ or facility used is a Participating Provider and treats the Emergency Medical Condition, or if the services obtained were by an Out-of-Network Provider while you received such services from the Out-of-Network Provider, benefits for Covered Services are payable at the In Network Benefit Level shown in the SBC.
2. Benefits for Covered Services for all Emergency Care will be payable at the In-Network Benefit Level.
3. In most instances, other than Emergency Services and Care, if the Health Professional and/ or facility used is Out-of-Network Provider, benefits for Covered Services are payable at the Out-of-Network Benefit Level specified in the Schedule of Benefits and Coverage.

Cost-Sharing Information

Deductible. Before the Plan begins paying expenses for Out-of-Network services covered under this POS Plan, you must satisfy the annual Deductible specified in the SBC. The Deductible means the amount a Participant must pay each calendar year for Covered Services from his or her own pocket before the Plan will make payments for eligible expenses. The individual Deductible or family Deductible must be satisfied each calendar year before any payment will be made for any Out-of-Network Claim.

Effective January 1, 2009 any eligible expenses credited by the Plan towards your Deductible requirement during the last three months of this Group Plan's prior calendar year will be reduced to the extent of such application for the next ensuing calendar year.

Only those eligible expenses submitted on Claims to AvMed will be credited toward the Deductible. Expenses that are not eligible will not be counted toward the satisfaction of the Deductible. Eligible expenses are only those expenses that do not exceed the Maximum Allowable Payment.

Coinsurance. Once the calendar year Deductible has been met, you are responsible for paying a percentage of eligible expenses. The coverage percentage, hereinafter called "Coinsurance" is specified in the SBC. You will be responsible for paying any charges not considered an eligible expense.

Prior Authorization of Covered Services

In order to determine whether services and supplies are Medically Necessary, certain Covered Services require Prior Authorization from AvMed. Prior Authorization ensures a Participant of receiving the most appropriate medical care available, in the most appropriate setting. If your Physician is a Participating Provider, then he or she will handle all authorizations, notifications and utilization reviews with AvMed.

If your doctor is not a Participating Provider, you are responsible for making sure your Physician or Health Professional calls AvMed to obtain Prior Authorization for a covered service when it is required. Please refer to your Member ID card for the telephone number where authorization may be obtained or have your Physician call 1-800-682-8633.

Before the service is performed, you should verify with your provider that the service has received Prior Authorization. If you are unable to secure verification from your provider, you may also call AvMed. **Please remember that failure to receive Prior Authorization of a service will result in a reduction in coverage. The amount of the reduction is $500.**

The following services require Prior Authorization:

- Inpatient services
- Observation services
- Residential Treatment
- Outpatient Surgery - In-network only
- Intensive Outpatient Programs
- Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging)
- Non-Emergency Ambulance
- Hysterectomy
- Dialysis Services
- Transplant services
- Select Medications Including Injectables
- Partial Hospitalization and Intensive Outpatient Services
- Cardiac rehabilitation

It is important to remember that Out-of-Network benefits for Hospital admissions not authorized in advance will be reduced by the amount shown in the SBC. This reduction will occur regardless of whether such confinements are deemed Medically Necessary. If hospitalization is extended without authorization beyond the number of days approved, benefits for the extra days will be similarly reduced. **Please remember that failure to obtain Prior Authorization of a service will result in a $500 penalty and a reduction in coverage**.

PARTICIPANTS ARE RESPONSIBLE AND WILL BE LIABLE FOR COPAYMENTS, DEDUCTIBLES AND/OR COINSURANCE WHICH MUST BE PAID TO HEALTH CARE PROVIDERS FOR CERTAIN SERVICES, AT THE TIME SERVICES ARE RENDERED, AS SET FORTH IN THE SBC.

8.01 **Allergy injections, allergy serum and allergy skin testing.**

8.02 **Ambulance Service.** For an emergency or when pre-authorized by AvMed, ambulance service to the nearest Hospital appropriately staffed and equipped to treat the condition will be covered.

8.02.01 Ground transportation to an alternative level of care when associated with an approved Hospital confinement; and

8.02.02 Air **Ambulance** transportation is covered only when the point of pick-up is inaccessible by land or when the distance or other obstacles are involved in

transporting a Member to the nearest emergency facility equipped to adequately treat the Emergency Medical Condition. See NSA definition at Section 2.02 Air Ambulance Service (Rotary Wing).

8.02.03 Any Participant requiring medical, Hospital, or ambulance services for Emergency Medical Services and Care, either while temporarily outside the Service Area or within the Service Area but before they can reach a Participating Provider, may receive the emergency benefits as specified under the Plan.

8.03 **Bariatric Surgery Services.** Treatment of control of clinically severe (Morbid Obesity). See Section 10.03 for Limitations.

8.04 **Cardiac Rehabilitation.** Cardiac rehabilitation is covered for acute myocardial infarction, percutaneous transluminal coronary angioplasty (PTCA), coronary artery bypass graft (CABG), repair or replacement of heart valve(s) or heart transplant. Coverage is limited to a maximum of thirty-six (36) visits per calendar year. See SBC for additional information regarding Copayments and Limitations.

8.05 **Child Cleft Lip and Cleft Palate Treatment.** Health Care Services for child cleft lip and cleft palate, including medical, dental, speech therapy, audiology, and nutrition services, for treatment of a child under the age of 18 who has a cleft lip or cleft palate are covered.

8.06 **Clinical Trials:** Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

8.06.01 cancer or other life-threatening disease or Condition. For purposes of this benefit, a life-threatening disease or Condition is one from which the likelihood of death is probable unless the course of the disease or Condition is interrupted.

8.06.02 cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as AvMed determines, a clinical trial meets the qualifying clinical trial criteria stated below.

8.06.03 surgical musculoskeletal disorders of the spine, hip and knees, which are not life-threatening, for which, as AvMed determines, a clinical trial meets the qualifying clinical trial criteria stated below.

8.06.04 Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial. Benefits are available only when the Participant is clinically eligible for participation in the qualifying clinical trial as defined by the researcher. Participants are required to use a Participating Provider for any clinical trials covered under this Plan

8.06.05 Routine patient care costs for qualifying clinical trials include:

a) Covered health services for which benefits are typically provided absent a clinical trial.

b) Covered health services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.

c) Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

8.06.06 Routine costs for clinical trials do not include:

a) the Experimental or Investigational service or item. The only exceptions to this are:

i. certain Category B devices.

ii. certain promising interventions for patients with terminal illnesses.

iii. other items and services that meet specified criteria in accordance with AvMed's medical and drug policies.

b) items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

c) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

d) items and services provided by the research sponsors free of charge for any person enrolled in the trial.

8.06.07 With respect to cancer or other life-threatening diseases or Conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or Condition and which meets any of the following criteria in the list below. With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees which are not life threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the list below.

a) Federally funded trials. The study or investigation is approved or funded by (which may include funding through in-kind contributions) by one or more of the following:

i. National Institutes of Health ("NIH"). (Includes National Cancer Institute.)

ii. Centers for Disease Control and Prevention.

iii. Agency for Healthcare Research and Quality.

iv. Centers for Medicare and Medicaid Services.

v. A cooperative group or center of any of the entities described above or the Department of Defense ("DOD") or the Veteran's Administration.

vi. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.

vii. The Department of Veteran Affairs, the DOD, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:

a. Comparable to the system of peer review of studies and investigations used by the NIH.

b. Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

b) The study or investigation is conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration.

c) The study or investigation is a drug trial that is exempt from having such an Investigational new drug application.

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

e) The subject or purpose of the trial must be the evaluation of an item or service that meets the requirements of a covered health service and is not otherwise excluded under the Plan. See Section 11.09 for Exclusions.

8.07 **Complications of Pregnancy.** Health care services provided to you or the treatment of complications of pregnancy are Covered Services and shall be treated the same as any other medical Condition. Complications of pregnancy include, but are not limited to:

8.07.01 Acute nephritis;

8.07.02 Nephrosis;

8.07.03 Cardiac decompensation;

8.07.04 Eclampsia (toxemia with convulsions);

8.07.05 Ectopic pregnancy;

8.07.06 Uncontrolled vomiting required fluid replacement;

8.07.07 Missing abortion (i.e., fatel death without spontaneous abortion);

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

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

8.07.10 Miscarriages;

8.07.11 Medical and surgical Conditions of similar severity; and

8.07.12 Medically Necessary non-elective cesarean section.

8.08 **Dermatological Services.** The Plan will cover office visits to a Dermatologist for Medically Necessary Covered Services.

8.09 **Diabetes Treatment** for all Medically Necessary equipment, supplies, and services to treat diabetes. This includes outpatient self-management training and educational services, if the Participant's Primary Care Physician, or the Physician to whom the Participant has been referred who specializes in diabetes treatment, certifies the equipment, supplies, or services are Medically Necessary. Insulin pumps are covered under the provisions for Durable Medical Equipment above. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator, registered dietitians/licensed nutritionist or a board certified endocrinologist.

8.10 **Diabetic Supplies.** Insulin, insulin syringes, alcohol swabs, lancets, and test strips are covered under the Prescription Drug benefit subject to applicable Copayments.

8.11 **Diagnosis and treatment of Autism Spectrum Disorder and Down syndrome** through speech therapy, occupational therapy, physical therapy and Applied Behavioral Analysis services for an individual under eighteen (18) years of age or an individual eighteen (18) years of age or older who is in high school and has been diagnosed as having a developmental disability at eight (8) years of age or younger.

8.11.01 Coverage shall be limited to services that are prescribed by the Covered Employee's treating Physician in accordance with a treatment plan. The treatment plan required shall include, but is not limited to, a diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated and the signature of the treating Physician.

8.11.02 Coverage is subject to applicable Copayment and coverage Limitation as outlined in the SBC.

8.12 **Diagnostic Imaging and Laboratory Services.** All prescribed diagnostic imaging, laboratory tests and services including diagnostic imaging, fluoroscopy, electrocardiograms, blood and urine and other laboratory tests, and diagnostic clinical isotope services are covered when Medically Necessary and ordered by a Physician as part of the diagnosis and/or treatment of a covered illness r injury or as preventive health care services.

8.13 **Diagnostic testing and treatment related to Attention Deficit Hyperactivity Disorder ("ADHD").**

8.14 **Dialysis Services.** Dialysis services including equipment, training, and medical supplies, are covered when provided at an AvMed approved or contracted facility, by a participating Health Professional licensed to perform dialysis, including an AvMed contracted Dialysis Center. A Dialysis Center is an outpatient facility certified by the Centers for Medicare and Medicaid Services and the Florida Agency for Health Care Administration to provide hemodialysis and peritoneal dialysis services and support. Dialysis services require Prior Authorization.

8.15 **Drug Infusion Therapy.** Infusion therapy medications are covered as a medical benefit if administered by a Health Professional by way of intracavernous, intramuscular, intraocular, intra-articular, intrathecal, intravenous or subcutaneous injection or intravenous infusion. Prior Authorization may be required.

8.16 **Durable Medical Equipment and Orthotic Appliances.**

8.16.01 Durable Medical Equipment. Charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by AvMed for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to an anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a Participant's misuse are the Participant's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by AvMed. See SBC for any Copayments or Limitations. See Part XI for Exclusions.

8.16.02 **Orthotic Appliances.** Coverage for orthoses and orthotic devices is provided for custom foot orthoses and other orthoses as follows:

a) Non-foot orthoses – only the following non-foot orthoses are covered:

i. Rigid and semi-rigid custom fabricated orthoses;

ii. Semi-rigid prefabricated and flexible orthoses; and

iii. Rigid prefabricated orthoses including preparation, fitting and basic additions such as bars and joints. For persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);

b) Custom foot orthoses – custom foot orthoses are only covered as follows:

i. When the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;

ii. When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of injury, illness, or congenital defect; and

iii. For persons with neurologic or neuromuscular Condition (e.g. cerebral palsy, hemiplegia, spinabifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement. See SBC for any Copayments or Limitations. See Part XI for Exclusions.

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

8.17 **Each Participant enrolled in the Plan** is encouraged, but not required, to select one Primary Care Physician upon enrollment. Types of PCPs include family, general and general medicine practitioners, OB/GYNs who may be selected as PCPs for women, and pediatricians who may be selected as PCPs for children. The Participant should notify AvMed prior to changing Primary Care Physicians. Health Professionals may from time to time cease their affiliation with any network. You are entitled to see a Specialty Health Care Professional without a referral from your PCP. In such cases, the Participant may select a new Health Professional, or the AvMed Member Engagement Center will refer you to a new Specialty Health Care Professional.

8.18 **Emergency Services.** All necessary Physician and Hospital Services will be covered by the Plan for Emergency Medical Services and Care. In the event that Hospital inpatient services are provided following emergency services, AvMed must be notified by the Hospital, Participant or designee, within 24 hours of the inpatient admission if reasonably possible. AvMed may elect to transfer the Participant to a Participating Provider after the Participant's Condition has been stabilized and as soon as it is medically appropriate to do so. If the Participant chooses to stay in the Non-Participating facility after the date AvMed decides a transfer is medically appropriate, Out-of-Network Benefit Levels may be available if the continued stay is determined to be a covered health service.

8.19 **Gender Transition.** Services to treat gender dysphoria, including gender reassignment surgery may be covered for Participants age 18 or over who are diagnosed with gender dysphoria by an AvMed Network Provider, when the recommended services are deemed Medically Necessary, and all criteria under AvMed's current coverage guidelines are met. Coverage determinations are made utilizing World Professional Association for Transgender Health (WPATH) criteria for surgery along with documentation of the specific clinical rationale for supporting the Participant's request for surgery. AvMed's detailed current coverage guidelines are available at www.avmed.org, or you may contact the AvMed Member Engagement Center to request a copy. See 11.22 for Exclusions.

8.20 **General Anesthesia and Hospitalization Services** to a Participant who is under 8 years of age and is determined by a licensed dentist and the Physician to require necessary dental treatment in a Hospital or Ambulatory Surgical Center due to a significantly complex dental Condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or if the Participant has one or more medical Conditions that would create significant or undue medical risk for the Participant in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center. Pre-authorization by AvMed is required. There is no coverage for diagnosis or treatment of dental disease.

8.21 **Habilitation Services.** Habilitation services coverage consist of the following:

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

8.21.02 Covered Services take place in a participating non-residential setting separate from the home or facility in which the Participant lives.

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

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

8.22 **Home Health Care Services (Skilled Home Health Care).** Charges made for Home Health Care Services when you:

8.22.01 Require skilled care which can only be provided by another Health Professional who is licensed by the state to provide such care;

8.22.02 Are unable to obtain required care as an ambulatory outpatient; and

8.22.03 Do not require confinement in a Hospital or Other Health Care Facility.

a) Home Health Care Services are provided only if AvMed determines that the home is a medically appropriate and cost effective setting.

b) Home Health Services are those skilled health care services that can be provided during visits by Other Health Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Professionals in providing Home Health Services are covered. If you are a minor or an adult who is dependent upon others for non-skilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your non-skilled care and/or custodial service needs. In no event will Home Health Services be considered a covered expense if the service can be provided by a family member (with or without additional training or instruction) or other unlicensed person. Home Health Services do not include services by a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house even if that person is an Other Health Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit Limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Care benefit Limitations in the SBC,

but are subject to the benefit Limitations described under Rehabilitation Services maximum shown in SBC.

8.23 **Hospice Services.** Services are available from a Hospice organization for a Participant whose Physician has determined the Participant's illness will result in a remaining life span of twelve (12) months or less.

8.24 **Hospital Care: Inpatient.** All Hospital inpatient services are provided when prescribed by Physicians and pre-authorized by AvMed. Inpatient Services include semi-private room and board, birthing rooms, newborn nursery care, nursing care, meals and special diets when Medically Necessary, use of operating room and related facilities, intensive care unit and services, diagnostic imaging, laboratory and other diagnostic tests, drugs and medications, biologicals, anesthesia and oxygen supplies, physical therapy, radiation therapy, respiratory therapy, and administration of blood or blood plasma.

8.25 **Infertility Services.** Charges made for services related to diagnosis of infertility and treatment of infertility once a Condition of infertility has been diagnosed. Services include, but are not limited to: approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; and diagnostic evaluation. Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis of both male and female infertility subject to the exclusions as outlined in Section 11.44.

8.26 **Inpatient Mental Health Services.** Services that are provided by a Hospital while you or your dependent is confined in a Hospital for the treatment and evaluation of mental health. Inpatient mental health services include Partial Hospitalization and mental health residential treatment services. Mental health residential treatment services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute mental health Conditions.

8.27 **Inpatient Substance Abuse Rehabilitation Services.** Services provided for rehabilitation, while you or your dependent is confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient substance abuse services include Partial Hospitalization sessions and residential treatment services. Substance abuse residential treatment services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute substance abuse Conditions.

8.28 **Mammograms.** Mammograms are covered in accordance with Florida Statues and the U.S. Preventive Services Task Force (USPSTF) preventative services recommendations. One baseline mammogram is covered for female Participants between the ages of 35 and 39; a mammogram is available every two years for female Participants between the ages of 40 and 49; and a mammogram is available every year for female Participants aged 50 and older.

8.28.01 In addition, one or more mammograms a year are available when based upon a Physician's recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of 30.

8.29 **Mastectomy Surgery when Performed for Breast Cancer.** If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Right's Act of 1988 (WHCRA). For individuals receiving mastectomy-related benefits, coverage for post-mastectomy reconstructive surgery shall include: 1) reconstruction of the breast on which

the mastectomy has been performed; 2) surgery and reconstruction on the other breast to produce a symmetrical appearance; and 3) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered. The length of stay will not be less than that determined by the Attending Physician to be Medically Necessary in accordance with prevailing medical standards and after consultation with the covered patient. Coverage is subject to any applicable Copayments and will require Prior Authorization of services as applicable to other surgical procedures or hospitalizations under the Plan. See 11.12 for Exclusions. If you would like more information on WHCRA benefits, call AvMed's Member Engagement Center at 1-800-682-8633.

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

8.30.01 **Inpatient intermediate** mental health and substance abuse services may be covered in conjunction with a 24-hour intensive, structure and supervised treatment program providing an inpatient level of care but in a non-Hospital environment, for those disorders that cannot be effectively treated in an outpatient or Partial Hospitalization environment.

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

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

8.30.04 Prior authorization is required for mental health and substance abuse inpatient and Partial Hospitalization services.

8.31 **Medical and surgical services** for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer reviewed, evidence based scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the Condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung, and Blood Institute ("NHLBI") as a body mass index ("BMI") of 40 kilograms or greater without comorbidities, or a BMI of 35-39 kilograms with comorbidities. The services are subject to the Limitations as outlined in Section 10.03.

8.32 **Newborn Care.** All services applicable for children under the Plan are covered for an enrolled newborn child of the Covered Employee or the enrolled newborn child of a Covered Dependent of the Covered Employee or the newborn adopted child of the Covered Employee (Part III), from the moment of birth, including the Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, and transportation costs to the nearest facility appropriately staffed and equipped to treat the newborn's Condition, when such transportation is Medically Necessary.

8.33 **Obstetrical and Gynecological Care.** An annual gynecological examination and Medically Necessary follow-up care detected at that visit are available without the need for a prior referral. Participants do not need Prior Authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a Health Professional in

the Plan's network who specializes in obstetrics or gynecology. The Health Professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating Health Professionals who specialize in obstetrics or gynecology, please refer to your provider directory or visit us online at www.avmed.org/mdc. Obstetrical care benefits as specified herein are covered and include Hospital care, anesthesia, diagnostic imaging, and laboratory services for Conditions related to pregnancy. The length of maternity stay in a Hospital will be determined to be Medically Necessary in compliance with Florida law and in accordance with the Newborns' and Mothers' Health Protection Act ("NMHPA"). Group health plans and health insurance issuers generally may not, under Federal law (including the NMHPA), restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child below certain levels. These levels are as follows:

8.33.01 Hospital stays of at least 48 hours following a normal vaginal delivery, or at least 96 hours following a cesarean section (under Federal law, the Plan may not require that your provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 or 96 hours, as appropriate);

8.33.02 The Attending Physician does not need to obtain authorization from AvMed to prescribe a Hospital stay of this length;

8.33.03 The Plan will cover an extended stay, if Medically Necessary; however, the Physician or Hospital must pre-certify the extended stay.

8.33.04 Shorter Hospital stays are permitted if the Attending Physician, in consultation with the mother, determines that to be the best course of action. Coverage for maternity care is subject to applicable Copayments or Coinsurance and all other Plan limits and requirements.

8.34 **Osteoporosis Diagnosis and Treatment** when Medically Necessary for high-risk individuals, e.g. estrogen-deficient individuals, individuals with vertebral abnormalities, individuals on long-term glucocorticoid (steroid) therapy, individuals with primary hyperparathyroidism, and individuals with a family history of osteoporosis.

8.35 **Ostomy supplies** and urinary catheter bags are covered when Medically Necessary. Provisions of ostomy and urostomy supplies are limited to a one-month supply every 30 days. Items which are not medical supplies or which could be used by the Participant or a family member for purposes other than ostomy care are not covered.

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

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

8.38 **Participating Providers.** The names and addresses of Participating Providers and Hospitals are set forth in a separate booklet which is incorporated herein by reference. The list of Participating Providers, which may change from time to time, will be provided to the County. The list of Participating Providers may also be accessed from the AvMed website at **www.avmed.org/mdc,** go to Quick Links, then click on the Participating Providers list. Notwithstanding the printed

booklet, the names and addresses of Participating Providers on file with AvMed at any given time shall constitute the official and controlling list of Participating Providers. Therefore, it is the Participant's responsibility to verify participation status prior to utilizing services.

8.39 **Payment to Non-Participating Providers.** When, in the professional judgment of AvMed's Medical Director, a Participant needs covered medical or Hospital Services which require skills or facilities not available from Participating Providers and it is in the best interest of the Participant to obtain the needed care from a Non-Participating Provider, upon authorization by the Medical Director, payment not to exceed the Maximum Allowable Payment for such Covered Services rendered by a Non-Participating Provider will be made by the Plan. Charges for non-participating hospital services will be reimbursed in accordance with the Covered Benefits the Participant would be entitled to receive in a participating Hospital. (See 2.54 for the definition of Maximum Allowable Payment).

8.40 **Physician Care: Inpatient.** All Medical Services rendered by Physicians and other Health Professionals when requested or directed by the Attending Physician, including surgical procedures, anesthesia, consultation and treatment by specialists, laboratory and diagnostic imaging services, and physical therapy are provided while the Participant is admitted to a Hospital as a registered bed patient. When available and requested by the Participant, the Plan covers the services of a certified nurse anesthetist.

8.41 **Physician Care: Outpatient**

8.41.01 **Diagnosis and Treatment.** All Medical Services rendered by Physicians and other Health Professionals are covered, including surgical procedures, routine hearing examinations and vision examinations for glasses for children under age 18 (such examinations may be provided by optometrists licensed pursuant to Chapter 463, *Florida Statutes* or by ophthalmologists licensed pursuant to Chapter 458 or 459, *Florida Statutes*), and consultation and treatment by Specialty Health Care Professionals. Also included are non-reusable materials and surgical supplies. These services and materials are subject to the Limitations outlined in Part IX (Limitations of Basic Benefits). See Part X for Exclusions.

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

8.41.03 **Outpatient Mental Health Services.** There is no requirement to obtain an authorization from your Primary Care Physician for individual or group therapy visits to the Provider of your choice.

8.42 **Prescription Drug Benefits.** Coverage for prescription drugs includes expenses for charges made by a pharmacy, for Medically Necessary prescription drugs ordered by a Physician or issued by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

Coverage for certain prescription drugs requires your Physician to obtain authorization prior to prescribing. Coverage for prescription drugs is subject to the Copayment or Coinsurance shown in the SBC.

8.43 **Prosthetic Devices.** The Plan provides benefits, when Medically Necessary, for Prosthetic devices. Coverage for Prosthetic devices includes but is not limited to basic limb prostheses; terminal devices such as hands or hooks; and speech prostheses. Coverage includes the initial purchase, fitting, or adjustment and is limited to the most appropriate and cost effective alternative as determined by AvMed. Repair and replacement are covered only when Medically Necessary due to a change in bodily configuration or due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered. Prosthetic Devices for Deluxe, Myo-electric and electronic prosthetic devices are not covered. (See Section 10.07 for Limitations, and Section 11.43 for Exclusions).

8.44 **Rehabilitative Therapy and Spinal Manipulation Services.** Short-term rehabilitative therapy is part of a rehabilitative program, including physical, occupational, cognitive, osteopathic manipulative, respiratory or speech therapy provided in the most medically appropriate setting. Also included are services that are provided by a chiropractic Physician when provided in an outpatient setting. Services of a chiropractic Physician include the conservative management of acute neuromusculoskeletal Conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function. Coverage of outpatient short-term rehabilitative therapy and spinal manipulation Services is limited to sixty (60) visits per calendar year for all services combined. Habilitative therapy is covered for the treatment of Autism Spectrum Disorder, subject to Section 8.11 and the Limitations in Part X. A separate Copayment will apply to the services provided by each provider.

8.45 **Second Medical Opinions.** The Participant is entitled to a second medical opinion when he: 1) disputes the appropriateness or necessity of a surgical procedure; or 2) is subject to a serious injury or illness.

8.45.01 The Participant may obtain the second medical opinion from any Participating or Non-Participating Physician. If a Participating Physician is chosen, there is no cost to the Participant other than any applicable Copayment. If the Participant chooses a Non-Participating Physician, the Participant will be responsible for 30% of the Maximum Allowable Payment, after the Deductible, for the second medical opinion.

8.45.02 Once a second medical opinion has been rendered, AvMed shall review and determine the treatment obligations of the Plan and that judgment is controlling. Any treatment the Participant obtains that is not authorized by AvMed shall be at the Participant's expense.

8.45.03 The Plan may limit second medical opinions in connection with a particular diagnosis or treatment to three (3) per calendar year, if AvMed deems additional opinions to be an unreasonable over-utilization by the Participant.

8.46 **Transplant services.** Transplant services are limited to the procedures listed below, are covered when performed at an AvMed contracted transplant facility, subject to the conditions and Limitations described below. Transplant services are subject to Prior Authorization. Transplant includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation.

8.46.01 The Plan will pay benefits only for services, care and treatment received or provided in connection with:

a) A Bone Marrow Transplant, which is specifically listed in Rule 59B-12.001, *Florida Administrative Code*, or any successor or similar rule or covered by Medicare as described in the most recently published Medicare Coverage Issues Manual issued by the Centers for Medicare and Medicaid Services. The Plan will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for the Participant and will be subject to the same Limitations and Exclusions as would be applicable to the Participant. Coverage for reasonable expenses of searching for the donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program.

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

b) corneal transplant;

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

d) heart-lung combination transplant;

e) liver transplant

f) kidney transplant;

g) pancreas only transplant;

h) pancreas transplant performed simultaneously with a kidney transplant;

i) lung - whole single or whole bilateral; or

j) intestine, which include small bowel, liver or multiple viscera

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

8.47 **Urgent Care Services.** All necessary and Covered Services received in Urgent Care or Immediate Care Centers or rendered in your Primary Care Physician's office after-hours for conditions as described in Section 2.61 will be covered by the Plan. See SBC for details. In addition, any Participant requests for reimbursement (of payment made by the Participant for services rendered) must be filed within ninety (90) days after the emergency or as soon as reasonably possible but not later than one (1) year unless the Claimant was legally incapacitated.

8.48 **Ventilator Dependent Care.** With Prior Authorization by AvMed, Ventilator Dependent Care is covered up to a total of 100 calendar day lifetime maximum benefit (See Part II. Section 2.92 for definitions, and Part IX, Section 10.20 for Limitations).

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

8.50 **Wound care supplies**, as part of an approved treatment plan, when one of the following criteria is met:

8.50.01 treatment of a wound caused by, or treated by, a surgical procedure; or

8.50.02 treatment of a wound that required debridement.

8.50.03 Provision of wound care supplies is limited to a one-month supply every thirty (30) days.

IX. AWAY FROM HOME

This Section describes the Plan's AWAY FROM HOME ("AFH") Program benefits and conditions of participation. For further information regarding the AFH Program, contact AvMed Member Engagement at 1-800-882-8633.

9.01 Notwithstanding any Plan provisions requiring Covered Services to be rendered by a Participating Provider and subject to the provisions set forth in 9.01, 9.03 – 9.09, the AFH Program allows for the following Covered Dependents of Covered Employees, who live inside the Service Area, access to Covered Services from Private Healthcare Systems, Inc. (PHCS) network providers outside the Service Area as follows:

9.01.01 Dependent child, under the age of 26, away at school, up to 4 years, or until the end of the calendar year the dependent reaches age 26, whichever comes first.

9.01.02 Dependent adult child, between the of age 26-30, away at school, beginning calendar year age 26 (the earliest) through the end of the calendar year the adult child reaches age 30 (the latest), requires proof of enrollment in school if they are residing outside of Florida.

9.01.03 Dependent child residing out of the Service Area with a custodial parent, with a proper court order.

9.01.04 Dependent child visiting a non-custodial parent for a period of more than thirty (30) days.

9.02 Notwithstanding any Plan provisions requiring Covered Services to be rendered by a Participating Provider and subject to the provisions set forth in 9.02 – 9.09, the AFH Program allows for a Covered Retiree, who lives in the Service Area, and the following Covered Dependents of the Covered Retiree, who lives in the Service Area, access to Covered Services from Private Healthcare Systems, Inc. (PHCS) network providers outside the Service Area as follows:

9.02.01 Covered Retiree and spouse for seasonal relocation (the AFH Program is limited to six (6) consecutive months if the retiree resides in the Service Area, and relocates for a seasonal period).

9.02.02 Dependent child, under the age of 26, away at school, up to 4 years, or until the end of the calendar year the dependent reaches age 26, whichever comes first.

9.02.03 Subject to meeting eligibility criteria for this age group each plan year, dependent adult child, between the of age 26-30, away at school, beginning calendar year age 26 (the earliest) through the end of the calendar year the adult child reaches age 30 (the latest).

9.02.04 Dependent child residing out of the Service Area with a custodial parent, with a proper court order.

9.02.05 Dependent child visiting a non-custodial parent for a period of more than thirty (30) days).

9.03 Any Covered Services provided by PHCS network providers to Covered Retiree, as applicable, and any Covered Dependents participating in the AFH Program will be paid as if they were rendered by a Participating Provider. All Plan procedures and guidelines must be followed for claims for services to be approved for payment under the AFH Program.

9.04 To be eligible for enrollment in the AFH Program, an individual must:

9.02.01 be a Covered Retiree, who lives inside the Service Area, as applicable; or

9.02.02 be a Covered Dependent under the Plan, of a Covered Employee or a Covered Retiree who lives inside the Services Area; and

9.02.02 reside outside the Service Area for a temporary, specified, period of time.

9.05 The following conditions apply for the enrollment of individuals in the AFH Program:

9.05.01 A Covered Employee or Covered Retiree must complete and submit the AFH Program enrollment form to AvMed's On-Site Representative or directly to AvMed's Member Engagement Department.

9.05.02 The AFH enrollment form must include a start and end date, the enrollment must be for a minimum of thirty (30) days.

9.05.03 Dependent children under age 26 away at school can have AFH up to 4 years, or until the end of the calendar year the dependent reaches age 26, whichever is first,

9.05.04 For Dependent children under age 26, once the dependent turns 26 a new AFH Program enrollment form is required, and if outside Florida, proof of student status is required to meet eligibility.

9.05.05 For Covered Retiree and spouse, the enrollment is limited to a maximum of six (6) consecutive months for seasonal relocation.

9.05.06 For Dependent child residing out of the Service Area with a custodial parent, with a proper court order, the assignment will be processed per the court order, a copy of the court order may be accepted in place of the AFH Program enrollment form. A retroactive assignment may be reviewed based on the child's effective date or date specified in a court order. If enrollment of the dependent child is without a court order, an AFH Program enrollment form must be completed.

9.06 All AFH enrollment forms will be reviewed by the AvMed Member Engagement Department and once approved the AvMed Member Engagement Department will set up those individuals with a designated AFH assignment. The AvMed Member Engagement will send a confirmation letter to the Covered Employee or Covered Retiree showing name of the individual and date span. If a

Covered Dependent or Covered Retiree wants to extend the enrollment, he/she must submit a new AFH Program enrollment form and provide revised end date.

9.07 The approved enrollment in the AFH Program will begin on the commencement date provided on the AFH Program letter. Retroactive assignments are limited to ninety (90) days from the date of receipt of the AFH Program The enrollment in the AFH Program will expire on the date provided on the AFH Program enrollment form. For a dependent child residing out of the Service Area with a custodial parent, with a proper court order, a retroactive assignment may be reviewed based on the child's effective date or date specified in a court order.

9.08 The individual enrolled in the AFH Program has the sole responsibility to identify himself/herself as a Plan Member, and to assure that any Covered Services received outside the Service Area, except for Emergency Medical Services and Care or Urgent Medical Services and Care, are rendered by a PHCS network provider. Any service, except for Emergency Medical Services and Care or Urgent Medical Services and Care, rendered outside the Service Area by a provider not in the PHCS network is not an AFH Program benefit and will be considered a service not covered under the Plan, unless prior arrangements have been made for the Member and confirmed by written referral or authorization from AvMed.

9.09 In the absence of an approved AFH Program enrollment form on-file with AvMed for the Covered Retiree, as applicable, or the Covered Dependent, who meets the required criteria set forth herein above, except for Emergency Medical Services and Care or Urgent Medical Services and Care, Plan shall have no liability or obligation whatsoever on account of services or benefits sought or received by any individual from any PHCS network provider, Non-Participating Provider or other person, institution or organization, unless prior arrangements have been made for the Member and confirmed by written referral or authorization from AvMed.

9.10 To determine if a PHCS network provider is available where the individual resides or attends school, please check the website at www.avmed.org/mdc and select "PHCS Directory".

X. LIMITATIONS OF BASIC BENEFITS

The rights of Participants and obligations of Participating Providers hereunder are subject to the following Limitations:

10.01 **Abortion Services.** Abortion services are covered when Medically Necessary.

10.02 **Acupuncture.** Acupuncture is limited to Out-of-Network only.

10.03 **Bariatric Surgery Services.** Treatment or Control of Clinically Severe (Morbid) Obesity:

10.03.01 Benefits for medical and surgical services for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer reviewed, evidence based scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the Condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a body mass index (BMI) of 40 kilograms or greater without comorbidities, or a BMI of 35-39 kilograms with comorbidities.

10.03.02 The following items are specifically excluded:

a) Medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity; and

b) Weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision. See Section 11.03 for additional Exclusions.

10.04 **Breast Reconstruction and Breast Prostheses:**

10.04.01 Covered Benefits for reconstructive surgery following a mastectomy include:

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

b) Mastectomy bras are limited up to 4 replacements bras within each 12 month time period. (See Section 11.04 for Exclusions).

10.05 **Custom foot orthoses** are only covered as follows:

10.05.01 For persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);

10.05.02 When the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;

10.05.03 When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of injury, sickness or congenital defect; and

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

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

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

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

10.07.01 External prosthetic appliances are not covered Out-of-Network.

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

a) Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.

b) Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

10.07.03 Coverage for replacement is limited as follows:

a) No more than once every 24 months for persons 19 years of age and older and

b) No more than once every 12 months for persons 18 years of age and under.

c) Replacement due to a surgical alteration or revision of the site.

10.08 **Eye Exam for Children.** Eye exam for children are limited to one (1) exam per year to determine the need for sight correction.

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

10.09.01 A person has symptoms or signs of a genetically-linked inheritable disease;

10.09.02 It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or

10.09.03 The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

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

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

10.10 **Habilitative physical, occupational & speech therapy services**, when provided for the treatment of Autism Spectrum Disorder and Down syndrome, are limited to a combined maximum of 100 visits per calendar year.

10.11 **Home Health Care.** Approved treatment plan required. Out-of-Network home health care is limited to sixty (60) skilled visits maximum per calendar year.

10.12 **Hospice Services.** Hospice services are limited to 360 day per Participant lifetime maximum. Physician certification is required.

10.13 **Hyperbaric Oxygen Treatments.** Services are limited to 40 treatments per condition as appropriate pursuant to the Centers for Medicare and Medicaid Services (CMS) guidelines, subject to cost-sharing as shown on the Schedule of Benefits.

10.14 **Infertility Treatment.** Coverage for infertility treatment is limited to testing and treatment for services performed in conjunction with an underlying medical Condition, testing performed exclusively to determine the cause of infertility, and treatment and/or procedures exclusively to restore fertility (e.g. procedures to correct infertility Condition). See 11.44 for Exclusions.

10.15 **Mental health and substance abuse** services in a Residential Treatment Facility are limited to a combined maximum of sixty (60) days per calendar year. (See Section 8.30 for Covered Service Benefits).

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

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

10.17.01 The deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or

10.17.02 The orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease or;

10.17.03 The orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital Condition.

10.17.04 Repeat or subsequent orthognathic surgeries for the same Condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

10.18 **Short-term Rehabilitative Therapy and Spinal Manipulation Services:**

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

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

10.18.03 Rehabilitative therapy is limited to sixty (60) visits per calendar year for chiropractic services, rehabilitative pulmonary, physical, speech, occupational, cognitive, and respiratory therapies combined.

10.18.04 Cardiac rehabilitation is limited to thirty-six (36) visits per calendar year.

10.19 **Skilled Nursing Care.** Skilled nursing care is limited to sixty (60) days per calendar year. Prior Authorization is required.

10.20 **Transplant Services.** Transportation benefits are limited to $200 per day up to $10,000 lifetime maximum for a companion to accompany the Participant (or two companions when the patient is a minor) and the Participant has to travel greater than a 50 mile radius to receive the transplant. This service is available only when the transplant is authorized at an AvMed contracted Transplant Center.

10.21 **Ventilator Dependent Care** is limited to 100 days lifetime maximum benefit. See Section 2.92 for definition.

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

XI. EXCLUSIONS FROM BASIC BENEFITS

Medical Services and benefits for the following classifications and conditions are not covered and are excluded from this Benefit Plan:

11.01 **Aids or devices** that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers,

Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.

11.02 **Any health care services to diagnose or treat an injury, which directly or indirectly, resulted from or is in connection with:**

11.02.01 Medical care connected with Armed Force services (for both sickness and injury); service received at military or government facilities; services received to treat an injury arising out of service in the Armed Forces, Reserves, and/or National Guard; or

11.02.02 Participation in, or commission of any act punishable by law as a misdemeanor or felony whether or not you are charged or convicted, or which constitutes a riot or rebellion; engaging in an illegal occupation;

11.02.03 Coverage for injuries described in Section 11.02.02 will be available for situations in which the Member demonstrates that the injury resulted from an act of domestic violence or from a medical Condition (including both physical or mental Conditions), whether or not the Condition has been diagnosed before the occurrence of the injury.

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

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

11.05 **Charges for or in connection with treatment of the teeth or periodontium** unless such expenses are incurred:

11.05.01 for a continuous course of dental treatment started within six months of an injury to sound natural teeth; or

11.05.02 made by a Hospital for Bed and Board or Necessary Services and Supplies; or

11.05.03 made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery; or

11.05.04 charges made by a Physician for any of the following Surgical Procedures: excision of epulis; excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth); intraoral drainage of acute alveolar abscess with cellulitis; alveolectomy; gingivectomy, for gingivitis or periodontitis.

11.06 **Charges made by a Hospital owned or operated** by or which provides care or performs services for, the United States Government:

11.06.01 unless there is a legal obligation to pay such charges whether or not there is insurance

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

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

11.09 **Clinical Trials:** Routine costs for clinical trials do not include:

11.09.01 The Experimental or Investigational service or item. The only exception to this are:

a) certain Category B devices;

b) certain promising interventions for patients with terminal illnesses;

c) other items and services that meet specified criteria in accordance with AvMed's medical and drug policies.

11.09.02 Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

11.09.03 service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

11.09.04 services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);

11.09.05 items and services provided by the research sponsors free of charge for any person enrolled in the trial.

11.10 **Complication of a non-covered service is not covered.**

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

11.12 **Cosmetic surgery** and therapies defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance, except for reconstructive surgery to correct and repair a functional disorder as a result of a disease, injury, or congenital defect; initial implanted prosthesis and reconstructive surgery incident to a mastectomy for cancer of the breast. (See Section 8.29 for Mastectomy Surgery when Preformed for Breast Cancer).

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

11.14 **Dental implants for any condition.**

11.15 **Durable Medical Equipment** items that are not covered include, but are not limited to the following:

11.15.01 Bed related items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses;

11.15.02 Bath related items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas;

11.15.03 Chairs, lifts and standing devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs;

11.15.04 Fixtures to real property: ceiling lifts and wheelchair ramps;

11.15.05 Car/van modifications;

11.15.06 Air quality items: air conditioners, room humidifiers, vaporizers, air purifiers and electrostatic machines;

11.15.07 Blood/injection related items: blood pressure cuffs, centrifuges, nova pens and needle less injectors; or

11.15.08 Other equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment, emergency alert equipment, and diathermy machines.

11.15.09 The replacement of Durable Medical Equipment solely because it is old or used is excluded.

11.16 **Expenses for supplies, care, treatment, or surgery** that is not Medically Necessary.

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

11.18 **Experimental and/or Investigational.** Charges for or in connection with Experimental, Investigational or unproven services. Experimental, Investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

11.18.01 not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;

11.18.02 not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;

11.18.03 the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or

11.18.04 the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.

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

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

11.21 **For or in connection with an injury or sickness** arising out of, or in the course of, any employment for wage or profit.

11.22 **Gender Transition.** Gender reassignment surgery, and any treatment, service, supply, or medication associated with or as a result of gender reassignment or gender dysphoria is excluded, except for Participants age 18 or over who are diagnosed with gender dysphoria by an AvMed Network Provider, and the recommended services are deemed Medically Necessary, and all criteria under AvMed's current coverage guidelines are met. See 8.19 for details.

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

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

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

11.26 **Massage Therapy.**

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

11.28 **Medical benefits for eyeglasses**, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.

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

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

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

11.32 **Orthopedic shoes**, arch supports, elastic stockings, garter belts, corsets, dentures and wigs (except under Section 10.07).

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

11.34 **Physical, Occupational, Speech and All Other Therapies for Chronic Conditions.** Maintenance therapy is not covered. Maintenance therapy begins when the therapeutic goals of a treatment plan have been met and/or no further functional progress is expected. Abnormal speech pathology, including lisping and stuttering, is not covered.

11.35 **Private Hospital rooms** unless semi-private rooms are not available and/or Private Duty Nursing except as provided under the Home Health Services provision.

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

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

11.38 **Sexual Dysfunction.** Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile

implants), anorgasmy, and premature ejaculation. Sexual dysfunction benefits are not available for drug therapies except certain drugs approved by the Plan and only to treat erectile dysfunction due to an organic cause.

11.39 **Short-term Rehabilitative Therapy and Spinal Manipulation Services** that are not covered include but are not limited to:

11.39.01 sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted Conditions without evidence of an underlying medical condition or neurological disorder;

11.39.02 treatment for functional articulation disorder such as correction of tongue thrust, lips, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical Condition or injury;

11.39.03 services that are custodial, instructional, educational or developmental in nature;

11.39.04 therapy or treatment intended primarily to improve or maintain general physical Condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

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

11.41 **Surgically implanted devices** and any associated external devices, except for cardiac pacemakers, intraocular lenses, cochlear implants in deaf children based on the likelihood for a successful outcome, ventricular assist devices (when used as a bridge to heart transplant), artificial joints and orthopedic hardware, vascular grafts, neurostimulators and implantable pain pumps. Dental appliances, other corrective lenses and hearing aids, including the professional fee for fitting them, are not covered.

11.42 **Telephone, e-mail, and Internet consultations, and telemedicine.**

11.43 **The following are specifically excluded external prosthetic appliances and devices**:

11.43.01 External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and

11.43.02 Myoelectric prostheses peripheral nerve stimulators.

11.44 **The following are specifically excluded infertility services:**

11.44.01 Artificial insemination;

11.44.02 In-vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;

11.44.03 Reversal of male and female voluntary sterilization;

11.44.04 Infertility services when the infertility is caused by or related to voluntary sterilization;

11.44.05 Donor charges and services;

11.44.06 Cryopreservation of donor sperm and eggs; and

11.44.07 Any Experimental, Investigational or unproven infertility procedures or therapies.

11.45 **The following are specifically excluded from Mental Health and Substance Abuse Services:**

11.45.01 Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement;

11.45.02 Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;

11.45.03 Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders;

11.45.04 Counseling for activities of an educational nature;

11.45.05 Counseling for borderline intellectual functioning;

11.45.06 Counseling for occupational problems;

11.45.07 Counseling related to consciousness raising;

11.45.08 Vocational or religious counseling; and

11.45.09 I.Q. testing.

11.46 **The following are specifically excluded from Spinal Manipulation Services:**

11.46.01 services of a chiropractor which are not within his scope of practice, as defined by state law;

11.46.02 charges for care not provided in an office setting;

11.46.03 vitamin therapy.

11.47 **The following are specifically excluded orthoses and orthotic devices:**

11.47.01 cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the Limitations and maximums of the External Prosthetic Appliances and Devices benefit;

11.47.02 orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;

11.47.03 orthoses primarily used for cosmetic rather than functional reasons;

11.47.04 orthoses primarily for improved athletic performance or sports participation; and

11.47.05 Copes scoliosis braces.

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

11.48.01 for the services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house;

11.48.02 for any period when you or your dependent is not under the care of a Physician;

11.48.03 for services or supplies not listed in the Hospice Care Program;

11.48.04 for any curative or life-prolonging procedures;

11.48.05 to the extent that any other benefits are payable for those expenses under the Plan;

11.48.06 for services or supplies that are primarily to aid you or your dependent in daily living.

11.49 **To the extent of the Exclusions** imposed by any certification requirement shown in this plan.

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

11.51 **To the extent that they are more than Maximum Allowable Payments.**

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

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

XII. COORDINATION OF BENEFITS

12.01 The services and benefits provided under the Plan are not intended and do not duplicate any benefit to which Participants are entitled under any other Group Health Insurance, HMO, Personal Injury Protection and medical payments under the automobile insurance laws of this or any other jurisdiction, governmental organization, agency, or any other entity providing health or accident benefits to a Participant, including but not limited to: Medicare, Worker's Compensation, Public Health Service, Champus, Maritime Health Benefits, or similar state programs as permitted by contract, policy, or law. Plan coverage will be primary to Medicaid benefits.

12.02 If any Participant is eligible for services or benefits under two or more plans as set forth above, the coverage under those plans will be coordinated so that up to but not more than 100% of any eligible expense will be paid for or provided by all such plans combined. The Participant shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Plan. Failure to do so will result in nonpayment of Claims. Requested information should be provided to AvMed within thirty (30) days of request or Participant will be responsible for payment of Claim. Information received after one (1) year from date the of service will not be considered.

12.03 The standards governing the coordination of benefits are the following:

12.03.01 The benefits of a policy or plan which covers the person as a Covered Employee or Participant, other than as a dependent, are determined before those of the policy or plan which covers the person as a dependent.

12.03.02 Except as stated below, when two or more policies or plans cover the same child as a dependent of different parents:

a) The benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls earlier in a year are determined before those of the policy or plan of the parent whose birthday, excluding year of birth, falls later in that year; but

b) If both parents have the same birthday, the benefits of the policy or plan which covered the parent for a longer period of time are determined before those of the policy or plan which covered the parent for a shorter period of time.

12.03.03 If two or more policies or plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a) First, the policy or plan of the parent with custody of the child;

b) Second, the policy or plan of the spouse of the parent with custody of the child; and

c) Third, the policy or plan of the parent not having custody of the child.

d) However, if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the child and if the entity obliged to pay or provide the benefits of the policy or plan of that parent has actual knowledge of those terms, the benefits of that policy or plan are determined first. This does not apply with respect to any Claim determination period or plan or policy year during which any benefits are actually paid or provided before that entity has that actual knowledge.

12.03.04 The benefits of a policy or plan which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a policy or plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other policy or plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this Subsection shall not apply.

12.03.05 If none of the above rules determine the order of benefits, the benefits of the policy or plan which covered the Participant for a longer period of time are determined before those of the policy or plan which covered that person for the shorter period of time.

12.03.06 Coordination of benefits shall not be permitted against an indemnity-type policy, an excess insurance policy as defined in Section 627.635, Florida Statutes, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.

12.03.07 If an individual is covered under a COBRA continuation plan as a result of the purchase of continuation coverage as provided under COBRA, and also under another group plan, the following order of benefits applies:

a) First, the plan covering the person as an employee, or as the employee's dependent.

b) Second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA.

12.04 For the purpose of determining the applicability and implementing the terms of the Coordination of Benefits provision of this agreement, AvMed may, without the consent of or notice to any person, release to or obtain from any other insurance company, organizations or person, any information, with respect to any Participant, which AvMed deems to be necessary for such purposes.

12.05 Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plans, the Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts the Plan shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be Benefits paid under this Plan.

12.06 All treatments must be Medically Necessary and comply with all terms, conditions, Limitations, and Exclusions of this Plan even if the Plan is secondary to other coverage and the treatment is covered under the other coverage.

12.07 Persons Eligible for Medicare

12.07.01 Medicare shall be considered the secondary plan and this Plan shall be considered the primary plan with respect to the following Participants entitled to Medicare:

a) For Medicare entitlement due to age, active employees and their spouses;

b) For Medicare entitlement due to disability, employees under this Plan due to current employment status and their family members;

c) For Medicare entitlement due to end-stage renal disease, all Participants during the first 30 months of Medicare entitlement.

12.07.02 For all other Participants entitled to Medicare, this Plan shall be secondary plan. When this Plan is secondary to Medicare, the amount payable under this Plan shall be reduced by the amount payable under Medicare, if any, regardless of whether the Participant has enrolled in Medicare.

12.07.03 A Participant who is eligible to be covered under Medicare, except a Participant actively employed by the County or the covered spouse of a Participant actively employed, must enroll in Medicare Parts A and B on the date eligible in order to continue coverage under the Plan.

12.08 Allowable Expense - a necessary, reasonable and customer service or expense, including deductibles, Coinsurance or Copayments that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service is the Allowable Expense and is paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

12.08.01 An expense or service or a portion of an expense or service that is not covered by any of the Plans is not considered an Allowable Expense.

12.08.02 If you are confined to a private Hospital room and no Plan provides coverage for more than a semi-private room, the difference in the cost between a private and semi-private room is not an Allowable Expense.

12.08.03 If you are covered by two or more Plans that provide services or supplies on the basis a Maximum Allowable Payment, any amount in excess of the Maximum Allowable Payment fee is not an Allowable Expense.

12.08.04 If you are covered by one Plan that provides services or supplies on the basis of a Maximum Allowable Payment and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

12.08.05 If your benefits are reduced under the Primary Plan (through the imposition of a higher Copayment amount, higher Coinsurance percentage, a Deductible and or penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and pre-certification of admission or services.

12.09 Effect on the Benefits of this Plan:

If this Plan is the secondary plan, this Plan may reduce benefits so that the total benefits paid by all plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the primary plan, and the benefit payments that this Plan had actually paid as the secondary plan, will be recorded as a benefit reserve for you. AvMed will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

12.09.01 As each Claim is submitted, AvMed will determine the following:

a) AvMed's obligation to provide services and supplies under this policy;

b) Whether a benefit reserve has been recorded for you; and

c) Whether there are any unpaid Allowable Expenses during the Claims Determination Period. If there is a benefit reserve, AvMed will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

XIII. SUBROGATION AND RIGHT OF RECOVERY

13.01 If the Plan provides health care benefits under this SPD to a Participant for injuries or illness for which another party is or may be responsible, then the Plan retains the right to repayment of the full cost of all benefits provided by the Plan on behalf of the Participant that are associated with the injury or illness for which another party is or may be responsible. The Plan's rights of recovery apply to any recoveries made by or on behalf of the Participant from the following third-party sources, as allowed by law, including but not limited to: payments made by a third-party tortfeasor or any insurance company on behalf of the third-party tortfeasor; any payments or awards under an uninsured or underinsured motorist coverage policy; any worker's compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; any other payments from a source intended to compensate a Participant for injuries resulting from an accident or alleged negligence. For purposes of this SPD, a tortfeasor is any party who has committed injury, or wrongful act done willingly, negligently or in circumstances involving strict liability, but not including breach of contract for which a civil suit can be brought.

13.02 Participant specifically acknowledges the Plan's right of subrogation. When the Plan provides health care benefits for injuries or illnesses for which a third party is or may be responsible, the Plan shall be subrogated to the Participant's rights of recovery against any party to the extent of the full cost of all benefits provided by the Plan, to the fullest extent permitted by law. The Plan may proceed against any party with or without the Participant's consent.

13.03 Participant also specifically acknowledges the Plan's right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when the Plan has provided health care benefits for injuries or illness for which another party is or may be responsible and the Participant and/or the Participant's representative has recovered any amounts from the third party or any party making payments on the third party's behalf. By providing any benefit under this SPD, the Plan is granted an assignment of the proceeds of any settlement, judgment or other payment received by the Participant to the extent of the full cost of all benefits provided by The Plan. The Plan's right of reimbursement is cumulative with and not exclusive of the Plan's subrogation right and the Plan may choose to exercise either or both rights of recovery.

13.04 Participant and the Participant's representatives further agree to:

a) Notify the Plan promptly and in writing when notice is given to any third party of the intention to investigate or pursue a Claim to recover damages or obtain compensation due to injuries or illness sustained by the Participant that may be the legal responsibility of a third party; and

b) Cooperate with the Plan and do whatever is necessary to secure the Plan's rights of subrogation and/or reimbursement under this SPD; and

c) Give the Plan a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from a third party to the extent of the full cost of all benefits

associated with injuries or illness provided by the Plan for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement); and

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

e) Do nothing to prejudice the Plan's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery, which specifically attempts to reduce or exclude the full cost of all benefits, provided by the Plan.

13.05 The Plan may recover the full cost of all benefits provided by the Plan under this SPD without regard to any Claim of fault on the part of the Participant, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. In the event the Participant or the Participant's representative fails to cooperate with the Plan, the Participant shall be responsible for all benefits paid by the Plan in addition to costs and attorney's fees incurred by the Plan in obtaining repayment.

XIV. DISCLAIMER OF LIABILITY

14.01 Neither the Plan nor AvMed directly employs any practicing Physicians nor any Hospital personnel or Physicians. These Health Care Providers are independent contractors and are not the agents or employees of the Plan. Therefore, neither AvMed, nor the Plan shall be liable for any negligent act or omission committed by any independent practicing Physicians, nurses, or medical personnel, nor any Hospital or Health Care Facility, its personnel, other Health Professionals or any of their employees or agents who may, from time to time, provide Medical Services to a Participant of the Plan. Furthermore, neither AvMed nor the Plan shall be vicariously liable for any negligent act or omission of any of these independent Health Professionals who treat Plan Participant(s).

14.02 Certain Participants may, for personal reasons, refuse to accept procedures or treatment recommended by Physicians. Physicians may regard such refusal to accept their recommendations as incompatible with the continuance of the Physician/patient relationship and as obstructing the provision of proper medical care. If a Participant refuses to accept the medical treatment or procedure recommended by the Physician and if, in the judgment of the Physician, no professionally acceptable alternative exists or if an alternative treatment does exist but is not recommended by the Physician, the Participant shall be so advised. If a Participant continues to refuse the recommended treatment or procedure, the Plan may terminate the Participant's coverage under the Plan as set forth in Part VII.

XV. REVIEW PROCEDURE

15.01 Participants are entitled to have any complaint regarding the services or benefits covered under the Plan reviewed in accordance with the procedures set forth below. The County has delegated the discretionary authority to interpret the Plan and to make Claim determinations to AvMed. The County retains the discretionary authority to determine whether you and your dependents are eligible to enroll for or continue coverage under the Plan. If your Claim for Plan benefits is denied, AvMed will give you written notice of the specific reason for the denial, specific references to the

Plan provisions on which your denial is based, a description of any additional information necessary to perfect your Claim and an explanation of the Plan's appeal procedures.

15.02 **Grievances Relating to Plan Services.**

15.02.01 AvMed encourages the informal resolution of complaints relating to Plan services (e.g. quality of service, office waiting times, Physician behavior or other concerns). However, if a Participant's complaint cannot be resolved in this manner (i.e. over the telephone), the Participant may submit his or her grievance in writing to the AvMed Member Engagement Center. AvMed shall acknowledge the written grievance and investigate the grievance. A written response regarding the disposition of the complaint shall be provided within sixty (60) days after receipt of the written grievance.

a) You may submit a grievance in writing to:

AvMed Member Engagement Center
P.O. Box 569008
Miami, FL 33256
Telephone: 1-800-682-8633
Fax: (305) 671-4736

15.03 **Urgent Care Claims**

15.03.01 Initial Claim. An Urgent Care Claim shall be deemed to be filed on the date received by AvMed on behalf of the Plan. AvMed shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after AvMed receives, either orally or in writing, the Urgent Care Claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. If such information is not provided, AvMed shall notify the Claimant as soon as possible, but not later than 24 hours after AvMed receives the Claim, of the specified information necessary to complete the Claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. AvMed shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

a) AvMed's receipt of the specified information; or

b) The end of the period afforded the Claimant to provide the specified additional information.

15.03.02 If the Claimant fails to supply the requested information within the 48 hour period, the Claim shall be denied. AvMed may notify the Claimant of its benefit determination orally or in writing. If the notification is provided orally, a written or electronic notification shall be provided to the Claimant no later than three (3) days after the oral notification.

15.03.03 First Level Appeal. A Claimant may appeal an Adverse Benefit Determination with respect to an Urgent Care Claim within (180) days of receiving the Adverse Benefit Determination. The Plan shall notify the Claimant, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Claimant's request for review of an Adverse Benefit Determination; except in limited cases when the Plan provides new information to the Claimant that the Plan is considering in the appeal, and gives the Claimant an opportunity to respond.

a) You may submit an appeal to:

AvMed Member Engagement Center
P.O. Box 569008
Miami, FL 33256

15.03.04 Second Level Appeal. If the Claimant is not satisfied with the first level appeal decision, he may request a second review within sixty (60) days from the denial of the first level appeal. During this process, a Claimant will be able to present the case, in person or via teleconference, to the AvMed Member Appeals Committee. The Plan shall notify the Claimant, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than three (3) calendar days after the Plan receives the Claimant's request for review of an Adverse Benefit Determination. The decision of the Member Appeals Committee shall be final for cases involving administrative issues, such as eligibility, benefit coverage Limitations and/or Exclusions of the Plan.

15.03.05 Third Level Appeal. If the Claimant is not satisfied with the prior decision on cases involving medical necessity or clinical appropriateness, he may request that the case be sent to an Independent Review Organization (IRO). This request must be received within (180) days of the 2nd Level Appeal decision. The IRO will render a recommendation within thirty (30) calendar days unless the request meets expedited criteria, in which case it will be resolved within three (3) days.

15.03.06 The IRO's recommendation will be binding. AvMed will notify the Claimant in writing of the IRO's decision and will take necessary steps to provide care in accordance with such recommendation.

15.03.07 You must exhaust all levels of administrative appeal prior to taking any other action including but not limited to filing suit.

15.03.08 If you would like AvMed to review the denial prior to filing an appeal, you may do so by calling AvMed Member Engagement Center at 1-800-682-8633 or by submitting the request in writing to this address:

AvMed Member Engagement Center
P.O. Box 569008
Miami, FL 33256

15.03.09 You may provide additional information to clarify or support your Claim. Persons who were not involved in the initial determination shall conduct an internal review. A decision will be made within thirty (30) working days and written notification will be provided to the Participant. However, this process in no way extends the sixty (60) day period in which you are required to contact AvMed.

15.04 **Pre-Service Claims**

15.04.01 Initial Claim. A Pre-Service Claim shall be deemed to be filed on the date received by AvMed on behalf of the Plan. AvMed shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after AvMed receives the Pre-Service Claim. AvMed may extend this period one time for up to fifteen (15) days, provided that AvMed determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, before the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which AvMed expects to render a decision. If such an extension is necessary

because the Claimant failed to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information. In the case of a failure by a Claimant to follow the Plan's procedures for filing a Pre-Service Claim, the Claimant shall be notified of the failure and the proper procedures to be followed in filing a Claim for benefits not later than five (5) days following such failure. The Plan's period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information. If the Claimant fails to supply the requested information within the forty-five (45) day period, the Claim shall be denied.

15.04.02 First Level Appeal. A Claimant may appeal an Adverse Benefit Determination with respect to a Pre-Service Claim within (180) days of receiving the Adverse Benefit Determination. The Plan shall notify the Claimant, of the Plan's determination on review within a reasonable period of time. Such notification shall be provided not later than fifteen (15) days after the Plan receives the Claimant's request for review of the Adverse Benefit Determination; except in limited cases when Plan provides new information to the Claimant that the Plan is considering in the appeal, and gives the Claimant an opportunity to respond.

a) You may submit an appeal to:

AvMed Member Engagement Center
P.O. Box 569008
Miami, FL 33256

15.04.03 Second Level Appeal. If the Claimant is not satisfied with the first level appeal decision, he may request a second review within sixty (60) days from the denial of the first level appeal. During this process, a Claimant will be able to present the case, in person or via teleconference, to the AvMed Member Appeals Committee. The Plan shall notify the Claimant, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than fifteen (15) calendar days after the Plan receives the Claimant's request for review of an Adverse Benefit Determination. The decision of the Member Appeals Committee shall be final for cases involving administrative issues, such as eligibility, benefit coverage Limitations and/or Exclusions of the Plan.

15.04.04 Third Level Appeal. If the Claimant is not satisfied with the prior decision on cases involving medical necessity or clinical appropriateness, he may request that the case be sent to an Independent Review Organization (IRO). This request must be received within (180) days of the 2nd Level Appeal decision. The IRO will render a recommendation within thirty (30) calendar days unless the request meets expedited criteria, in which case it will be resolved within three (3) days.

15.04.05 The IRO's recommendation will be binding. AvMed will notify the Claimant in writing of the IRO's decision and will take necessary steps to provide care in accordance with such recommendation.

15.04.06 You must exhaust all levels of administrative appeal prior to taking any other action including but not limited to filing suit.

15.04.07 If you would like AvMed to review the denial prior to filing an appeal, you may do so by calling AvMed Member Engagement Center at 1-800-682-8633 or by submitting the request in writing to this address:

AvMed Member Engagement Center
P.O. Box 569008
Miami, FL 33256

15.04.08 You may provide additional information to clarify or support your claim. Persons who were not involved in the initial determination shall conduct an internal review. A decision will be made within thirty (30) working days and written notification will be provided to the Participant. However, this process in no way extends the sixty (60) day period in which you are required to contact AvMed.

15.05 **Post-Service Claims**

15.05.01 Initial Claim. A Post-Service Claim shall be deemed to be filed on the date received by AvMed on behalf of the Plan. AvMed shall notify the Claimant, of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after AvMed receives the Post-Service Claim. AvMed may extend this period one time for up to fifteen (15) days, provided that AvMed determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, before the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which AvMed expects to render a decision. If such an extension is necessary because the Claimant failed to submit the information necessary to decide the Post-Service Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information. The Plan's period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information. If the Claimant fails to supply the requested information within the forty-five (45) day period, the Claim shall be denied.

15.05.02 First Level Appeal. A Claimant may appeal an Adverse Benefit Determination with respect to a Post-Service Claim within (180) days of receiving the Adverse Benefit Determination. The Plan shall notify the Claimant, of the Plan's determination of review within a reasonable period of time. Such notification shall be provided not later than thirty (30) days after the Plan receives the Claimant's request for review of the Adverse Benefit Determination; except in limited cases when the Plan provides new information to the Claimant that the Plan is considering in the appeal, and gives the Claimant an opportunity to respond.

a) You may submit an appeal to:

AvMed Member Engagement Center
P.O. Box 569008
Miami, FL 33256

15.05.03 Second Level Appeal. If the Claimant is not satisfied with the first level appeal decision, he may request a second review within sixty (60) days from the denial of the first level appeal. During this process, a Claimant will be able to present the case, in person or via teleconference, to the AvMed Member Appeals Committee. The Plan shall notify the Claimant, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than thirty (30) calendar days after the Plan receives the Claimant's request for review of an Adverse Benefit Determination. The decision of the Member Appeals Committee shall be final for cases involving administrative issues, such as eligibility, benefit coverage Limitations and/or Exclusions of the Plan.

15.05.04 Third Level Appeal. If the Claimant is not satisfied with the prior decision on cases involving medical necessity or clinical appropriateness, he may request that the case be sent to an Independent Review Organization (IRO). This request must be received within (180) days of the 2nd Level Appeal decision. The IRO will render a recommendation within thirty (30) calendar days unless the request meets expedited criteria, in which case it will be resolved within three (3) days.

15.05.05 The IRO's recommendation will be binding. AvMed will notify the Claimant in writing of the IRO's decision and will take necessary steps to provide care in accordance with such recommendation.

15.05.06 You must exhaust all levels of administrative appeal prior to taking any other action including but not limited to filing suit.

15.05.07 If you would like AvMed to review the denial prior to filing an appeal, you may do so by calling AvMed Member Engagement Center at 1-800-682-8633 or by submitting the request in writing to this address:

AvMed Member Engagement Center
P.O. Box 569008
Miami, FL 33256

15.05.08 You may provide additional information to clarify or support your Claim. Persons who were not involved in the initial determination shall conduct an internal review. A decision will be made within thirty (30) working days and written notification will be provided to the Participant. However, this process in no way extends the sixty (60) day period in which you are required to contact AvMed.

15.06 **Concurrent Care Claims**

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

15.06.02 Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that relates to an Urgent Care Claim shall be decided as soon as possible, taking into account the medical exigencies, and AvMed shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after AvMed receives the Claim, provided that any such Claim is made to AvMed at least 24 hours before the expiration of the prescribed period of time or number of treatments. Notification and appeal of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving an Urgent Care Claim or not, shall be made in accordance with the remainder of this section.

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

15.07.01 The specific reason(s) for the Adverse Benefit Determination.

15.07.02 Reference to the specific Plan provisions on which the determination is based

15.07.03 A description of any additional material or information necessary for the Claimant to

perfect the Claim and an explanation of why such material or information is necessary.

15.07.04 A description of the Plan's review procedures and the time limits applicable to such procedures following an Adverse Benefit Determination on final review.

15.07.05 If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Averse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy shall be provided free of charge to the Claimant upon request.

15.07.06 If the Adverse Benefit Determination is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Health Plan to the Claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request.

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

15.08 **Review Procedure Upon Appeal.** The Plan's appeal procedures shall include the following substantive procedures and safeguards:

15.08.01 Claimant may submit written comments, documents, records, and other information relating to the Claim.

15.08.02 Upon request and free of charge, the Claimant shall have reasonable access to and copies of any Relevant Document.

15.08.03 If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

15.08.04 The appeal shall take into account all comments, documents, records, and other information the Claimant submitted relating to the Claim, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

15.08.05 The appeal shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit Determination nor the subordinate of such individual. Such person shall not defer to the initial Adverse Benefit Determination.

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

15.08.07 The appeal shall provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination.

15.08.08 The appeal shall provide that the Health Professional engaged for proposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the

appeal, nor the subordinate of any such individual.

15.08.09 In the case of an Urgent Care Claim, there shall be an expedited review process pursuant to which:

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

b) All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious methods.

15.09 **Manner and Content of Appeal Notification.** The Plan shall provide a Claimant with written or electronic notification of the Plan's benefit determination upon review.

15.09.01 In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Claimant, all of the following, as appropriate:

a) The specific reason(s) for the Adverse Benefit Determination.

b) Reference to the specific Plan provisions on which the Adverse Benefit Determination is based.

c) A statement that the Claimant is entitled to receive, upon request, and free of charge, reasonable access to, and copies of any Relevant Document.

d) A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures.

e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy shall be provided free of charge to the Claimant upon request.

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

15.10 **Remedies if Process "Deemed Exhausted".** If AvMed continues to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your Claim by an independent 3rd party, who will review the denial and issue a final decision. You may contact AvMed Member Engagement Center at 1-800-682-8633 with any questions on your rights to external review. Please understand that if you want to be informed about the legal remedies that may be available to you and whether they are a better option for you than seeking independent external review, you should consult a lawyer of your choice. AvMed cannot provide you with legal advice. AvMed can only explain the procedures for obtaining independent external review.

XVI. MISCELLANEOUS

16.01 **Clerical Errors.** Clerical error(s) shall neither deprive any individual Participant of any benefits or coverage provided under the Plan nor shall such error(s) act as authorization of benefits or coverage for the Participant that is not otherwise validly in force.

16.02 **Gender.** Whenever used, the singular shall include the plural and the plural the singular and the use of any gender shall include all genders.

16.03 **Identification Cards.** Cards issued by AvMed to Participants pursuant to the Plan are for purposes of identification only. Possession of an identification card confers no right to health services or other benefits under the Plan. To be entitled to such services or benefits the holder of the card must, in fact, be a Participant on whose behalf all applicable charges under the Plan have actually been paid and accepted by the Plan.

16.04 **Individual Information.** Participants or other individuals shall complete and submit to the Plan such applications, forms or statements as the Plan may reasonably request. If Participant or other individual fails to provide accurate information which the Plan deems material to providing coverage for such individual, upon ten (10) days written notice, the Plan may deny coverage and/or participation in the Plan to such individual.

16.05 **Plan Administration.** The County may from time to time adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of the Plan.

16.06 **Waiver.** A Claim which has not been timely filed with the Plan within one (1) year of date of service shall be considered waived.