



Summary Plan Description
of the
MDC High Option HMO,
MDC Jackson First HMO
and
MDC Select HMO
for the
Miami-Dade County Health Plan

Contract No. 00196

January 1, 2025 through December 31, 2025

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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 and Facilities are considered in-network for these counties.
Employees and their dependents residing outside the Service Area.**

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 through a network of contracted independent Physicians and Hospitals and Other Health Care 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 for your reference and is subject to various legal requirements, including the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

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 Non-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.

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, the primary purpose of which is to provide elective surgical care, in which the 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 Extended Network (PHCS)**. Private Healthcare Systems (PHCS) means a proprietary Preferred Provider Organization with whom AvMed has entered into an agreement to provide Medical Services outside AvMed's Service Area. The Point of Service Plan provides access to the PHCS Provider Network as defined herein. Participant's Copayment, Deductible and Coinsurance responsibilities are outlined in the SBC.
- 2.09 **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.

- 2.10 **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.
- 2.11 **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.
- 2.12 **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; provide 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 **Concurrent Care** means an ongoing course of treatment to be provided over a period of time or number of treatments that AvMed previously approved.
- 2.17 **Condition** means a disease, illness, ailment, injury, or pregnancy.
- 2.18 **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.
- 2.19 **County** means **Miami-Dade County**.
- 2.20 **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.

- 2.21 **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.
- 2.22 **Covered Employee** means an employee of the County who meets all of the applicable requirements of the Plan and is enrolled in the Plan.
- 2.23 **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.
- 2.24 **Covered Retiree Dependent** means a former employee's dependent who meets all of the applicable requirements of the Plan and is enrolled in the Plan.
- 2.25 **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.
- 2.26 **Deductible** means the 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.
- 2.27 **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.
- 2.28 **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:
 - 2.28.01 Are not married under Florida law, a partner to another domestic partnership relationship or a member of another civil union;
 - 2.28.02 Are not related to the other by blood;
 - 2.28.03 Are at least eighteen years of age;
 - 2.28.04 Are mentally competent to consent to a contract;
 - 2.28.05 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;
 - 2.28.06 Have filed a domestic partnership registration with the Consumer Services Department.
 - 2.28.07 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
 - 2.28.08 Reside in the same primary residence.

- 2.29 **Durable Medical Equipment (DME), Orthotics, and/or Prosthetics.** Coverage for DME, Orthotics and Prosthetics is limited as outlined in Part VIII. SCHEDULE OF BASIC BENEFITS subject to specific Exclusions as listed in Part XI. EXCLUSIONS FROM BASIC BENEFITS. 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.
- 2.30 **Emergency Medical Condition** means: a medical Condition, including a mental health 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:
- 2.30.01 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
- 2.30.02 Serious impairment to bodily functions
- 2.30.03 Serious dysfunction of any bodily organ or part.
- 2.30.04 Examples of Emergency Medical Conditions include, but are not limited to: heart attack, stroke, massive internal or external bleeding, fractured limbs, or severe trauma.
- 2.31 **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.
- 2.31.01 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.
- 2.31.02 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.

- 2.32 **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:
- 2.32.01 ambulatory patient services;
 - 2.32.02 emergency services;
 - 2.32.03 hospitalization;
 - 2.32.04 laboratory services;
 - 2.32.05 maternity and newborn care;
 - 2.32.06 mental health and substance abuse disorder services (including Behavioral Health treatment);
 - 2.32.07 pediatric services (including oral and vision care);
 - 2.32.08 prescription drugs;
 - 2.32.09 preventive wellness services and chronic disease management; and
 - 2.32.10 rehabilitative and habilitative services and devices.
- 2.33 **Exclusion** means any provision of this Plan whereby coverage for a specific service or Condition is entirely eliminated.
- 2.34 **Experimental and/or Investigational** means a drug, treatment, device, surgery or procedure that AvMed, in its discretion, determines to be Experimental and/or Investigational if any of the following applies:
- 2.34.01 The Food and Drug Administration (“FDA”) has not granted the approval for general use; or
 - 2.34.02 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
 - 2.34.03 There is no consensus among practicing Physicians that the medications, 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
 - 2.34.04 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.
- 2.35 **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.

- 2.36 **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*.
- 2.36.01 The terms “amount of insurance” and “insurance” include the benefits provided under a plan of self-insurance;
- 2.36.02 The term “insurer” includes any person, entity or governmental unit providing a plan of self-insurance; and
- 2.36.03 The term “policy,” “insurance policy,” health insurance policy,” and “Group Health Insurance policy” include plans of self-insurance providing health insurance benefits.
- 2.37 **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.
- 2.37.01 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.
- 2.37.02 Covered Services take place in a participating non-residential setting separate from the home or facility in which the Participant lives.
- 2.37.03 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.
- 2.37.04 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.
- 2.37.05 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).

- 2.38 **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:
- 2.38.01 A Hospital;
 - 2.38.02 A Hospital outpatient department;
 - 2.38.03 A critical access Hospital, and
 - 2.38.04 An ambulatory surgical center
- 2.39 **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.
- 2.40 **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.
- 2.41 **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.
- 2.42 **Hospice** means a public agency or private organization which is duly licensed by the State of Florida to provide Hospice services, including facilities with the AvMed Extended Network (PHCS), excluding MDC Select HMO Network, and MDC Jackson First HMO Network. Such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill Participants.
- 2.43 **Hospital** means any facility properly licensed pursuant to Chapter 395, Florida Statue, and with which AvMed has contracted or established arrangements, including those facilities within the AvMed Extended Network (PHCS), excluding MDC Select HMO Network, for inpatient Hospital Services and/or emergency services, and shall at times be referred to as “Participating Hospital”. Hospital services offers more intensive than those required for room, board, personal services and general nursing care; offered facilities and bed 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.
- 2.43.01 If services specifically or 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 scope of Covered Services. It only expands the setting where Covered Services can be performed for coverage purposes.
- 2.44 **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.

- 2.45 **Hospital Services** (except as expressly limited or excluded by the Plan) means those services for registered bed patients which are:
- 2.45.01 Generally and customarily provided by acute care general Hospitals within the Service Area;
 - 2.45.02 Performed, prescribed, or directed by Health Professionals; and
 - 2.45.03 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.
- 2.46 **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.
- 2.47 **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.
- 2.48 **Injectable Medication** means a medication that is approved by the Food and Drug Administration (FDA) for administration by one or more of the following routes: intramuscular, intravenous, subcutaneous injection, or intra-articular injection. Pre-authorization is required for Injectable Medications.
- 2.49 **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.
- 2.50 **Limitation** means any provision other than an Exclusion which restricts coverage under the Plan.
- 2.51 **Maximum Allowable Payment** means the maximum amount that Plan will pay for any covered service rendered by a Non-Participating Provider or supplier of services, medications or supplies.
- 2.52 **MDC High Option HMO Network** is comprised of conveniently located Hospitals, facilities, Physicians, and other healthcare providers.
- 2.53 **MDC Jackson First HMO Network** is limited to University of Miami and Jackson Health System conveniently located Hospitals, facilities, Physicians and other healthcare providers located in Dade, Broward, and Palm Beach counties.
- 2.54 **MDC Select Network** is comprised of conveniently located Hospitals, facilities, Physicians and other healthcare providers located in Dade, Broward, and Palm Beach counties.
- 2.55 **Medical Office** means any outpatient facility or Physician's office utilized by a Participating Provider.
- 2.56 **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:
- 2.56.01 Generally, and customarily provided in the Service Area;
 - 2.56.02 Performed, prescribed, or directed by Participating Providers; and
 - 2.56.03 Medically Necessary (except for preventive services as stated herein) for the diagnosis and treatment of injury or illness.

- 2.57 **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 which is necessary for the diagnosis, care, and/or treatment of a Participant's illness or injury, and which is:
- 2.57.01 Consistent with the symptom, diagnosis, and treatment of the Participant's condition;
 - 2.57.02 The most appropriate level of supply and/or service for the diagnosis and treatment of the Participant's condition;
 - 2.57.03 In accordance with standards of acceptable community practice;
 - 2.57.04 Not primarily intended for the personal comfort or convenience of the Participant, the Participant's family, the Physician, or other Health Care Provider;
 - 2.57.05 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;
 - 2.57.06 Prescribed, directed, authorized, and/or rendered by a participating or authorized provider, except in the case of an emergency; and
 - 2.57.07 Not Experimental and/or Investigational.
- 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 Provider** means any Health Professional or group of Health Professionals or Hospital, Medical Office, or Other Health Care Facility with whom AvMed has neither made arrangements nor contracted to render the professional health services set forth herein.
- 2.62 **Other Health Care Facility(ies)** 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 for which AvMed has contracted or established arrangements for providing these services to Participants.
- 2.63 **Partial Hospitalization** means outpatient treatment in which an individual receives at least six clinical hours of institutional care per day (24-hour period) for at least five days per week and returns home or is not treated as an inpatient during the remainder of that (24-hour period). A Hospital shall not be considered a "Home" for purposes of this definition.
- 2.64 **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.
- 2.65 **Participating Physician** means any Participating Physician licensed 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 Participating Physician primarily responsible for the care of a Participant with respect to any particular injury or illness. For Participants residing outside of the AvMed Service Area, Participating Physicians include the AvMed Extended Network (PHCS), excluding MDC Jackson First and MDC Select HMO Network.

- 2.66 **Participating Provider** means any Health Professional or group of Health Professionals or Hospital, Medical Office, or Other Health Care Facility with whom AvMed has made arrangements or contracted to render the professional health services set forth herein. For Participants residing outside of the AvMed Service Area, Participating Providers include the AvMed Extended Network (PHCS), excluding MDC Jackson First and MDC Select HMO Network.
- 2.67 **Plan** means the **Miami-Dade County Group Health Plan** sponsored by the County to provide covered Medical Services to Participants.
- 2.68 **Plan Administrator** means **Miami-Dade County**.
- 2.69 **Post-Service Claim** means any Claim for benefits under the Plan that is not a Pre-Service Claim.
- 2.70 **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.
- 2.71 **Primary Care Physician** means a Participating Physician engaged in family practice, pediatrics, internal medicine, obstetrics/gynecology, osteopathy, or any specialty Physician from time to time designated by AvMed as “Primary Care Physician” in AvMed’s current list of Physicians and Hospitals.
- 2.71.01 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 primary care provider, contact the Plan Administrator, or visit www.avmed.org/mdc. For children, you may designate a pediatrician as the primary care provider.
- 2.72 **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 Participant by arrangements between the Participant and the private-duty nurse or attendant. Such persons are engaged or paid by an individual Participant or by someone acting on their behalf, including a Hospital that initially incurs the costs and looks to the Participant for reimbursement for such services.
- 2.73 **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.
- 2.74 **Relevant Document** means any documentation that:
- 2.74.01 Was relied upon in making the benefit determination;
- 2.74.02 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.
- 2.74.03 Demonstrated compliance with the administrative process; and

- 2.74.04 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.
- 2.75 **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.
- 2.76 **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.
- 2.77 **Specialty Health Care Professional** means a Health Professional other than the Participant's chosen Primary Care Physician.
- 2.78 **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.
- 2.79 **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.
- 2.80 **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.
- 2.81 **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, use of Non-Participating Providers, 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.
- 2.82 **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 calendar days lifetime maximum.

2.83 Virtual Visits

- 2.83.01 **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.
- 2.83.02 **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. At the time of retirement, the coverage options will be made available. 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 the Covered Retiree if enrolled while an active employee; a new spouse must be enrolled within forty-five (45) days after marriage or registration of domestic partnership. Coverage is effective on the first day of the month following receipt of the application; or may request to enroll if the spouse loses 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 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 thirty-one (31) days from birth, the premium is waived for the first thirty one (31) days. If the CIS Form is received after the first thirty-one (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 thirty-one (31) days from the earlier of: (1) adoption or (2) placement for adoption. If the CIS Form is received after the first thirty-one (31) days, but within sixty (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 the *Florida Statute* 641.31(a). Payroll changes to 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 the child of a Covered Retiree, between the ages of 26 to age 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 may 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 Student 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 Full-Time Student 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. ELIGIBILITY 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 Service Area;
- i) The eligible employee or dependent completes and submits an Enrollment or Status Change request within forty-five (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; and
- e) The eligible Participant or dependent completes and submits an Enrollment or Status Change form within forty-five (45) days of the date the dependent becomes eligible (or within sixty (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 form 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 an enrollment form on behalf of such dependent. If received by the Plan within the forty-five (45) day time period (or 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 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 & COPAYMENTS

- 6.01 **Copayments 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 the Member has satisfied the Deductible amount specified on the Schedule of Benefits, the Member must pay any applicable Copayments or Coinsurance for Covered Benefits. Covered Benefits that apply are shown on the Schedule of Benefits.
- 6.02 **Annual maximum out-of-pocket limits** (as described in your Schedule of Benefits). The Copayments and Coinsurance you pay for Covered Benefits received during any Calendar Year

are accumulated toward your annual maximum out-of-pocket limit. Amounts paid as penalties do not count toward any out-of-pocket limits. Once you meet your individual or family annual maximum out-of-pocket limit 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 maximum out-of-pocket limits have been reached.

- 6.03 **Additional Expenses You Must Pay.** Expenses that do not count toward the annual maximum out-of-pocket expense limit are:
- 6.03.01 expenses related to charges for non-Covered Services including charges exceeding the Maximum Allowable Payment;
 - 6.03.02 additional charges incurred for failure to pre-authorize a service requiring Prior Authorization;
 - 6.03.03 expenses that relate to services that exceed any specific treatment Limitations noted in the Schedule of Benefits, and
 - 6.03.04 Brand Additional Charges for prescription medications.
- 6.04 **Estimate of Cost for Services.** You must 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 on this SPD apply.
- 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 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 the Plan 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 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 sixty (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 sixty (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 fourteen (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 sixty (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 members 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 sixty (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 COBRA plan administrator by the first day of the month for which the premium is due. (Your first payment is due no later than forty-five (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 sixty (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 your Covered Dependents, if your dependents lose eligibility for medical coverage due to your death, your 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 sixty (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 sixty (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 thirty (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 a 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 Participants responsibility when seeking benefits under the Plan to identify himself as a Plan Participant and to assure that the services received by the Participant are being rendered by Participating Providers.

County employees, under 65 retirees, and Covered Dependents who enroll in the MDC Select HMO or the MDC First Choice e HMO must receive all medical care, except emergencies and urgent care services, through an AvMed contracted MDC Select HMO Network provider, or MDC Jackson First HMO provider.

The Jackson First HMO Network is limited to University of Miami and Jackson Health System conveniently located hospital, facilities, Physicians and other healthcare providers. County employees, under 65 retirees, and Covered Dependents who enroll in the MDC First Choice HMO option must receive all medical care, except emergencies and urgent care services, through an AvMed contracted MDC Jackson First HMO provider.

*Please confirm with your AvMed provider his/her hospital privileges before obtaining Medical Services.

You can also receive Covered Services from any participating AvMed provider in the following categories:

- Chiropractic Care
- Durable Medical Equipment
- Independent Diagnostic Testing Facilities
- Independent Ambulatory Surgery Center
- Home Health
- Laboratory
- Mental Health,/Behavioral Health/Substance Abuse, *please contact Optum 1-866-293-2689*
- Outpatient Therapy
- Podiatry
- Optometry
- Pharmacies

To locate a participating AvMed provider in these and other categories, please visit the online provider search at www.avmed.org/mdc, go to Quick Links, click Elite Network, MDC Select HMO Network, or MDC Jackson First HMO Network.

Participants should remember that services that are provided or received without having been authorized in advance by AvMed's Medical Department, or if the service is beyond the scope of practice authorized for that Provider under state law, except in instances of Emergency Medical Services and Care, are not covered unless such services otherwise have been expressly authorized under the terms of the Plan. Except for Emergency Services and Care, all services must be received from Participating Providers. If a Participant does not follow the access rules, he risks having services and supplies received not covered under the Plan. In such a circumstance, the Participant will be responsible for reimbursing the Plan for the reasonable cost of the services and supplies received. The following services require Prior Authorization from AvMed:

- 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
- Use of Non-Participating Providers
- Select Medications Including Injectables
- Partial Hospitalization and Intensive Outpatient Services
- Cardiac rehabilitation

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 FROM BASIC BENEFITS), 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.

PARTICIPANTS ARE RESPONSIBLE AND WILL BE LIABLE FOR COPAYMENTS 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, treatment and 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. Ambulance services are as follows:

- 8.02.01 Local professional air/ground ambulance transport for emergency services to the nearest emergency facility appropriately staffed and equipped to treat a medical Condition;
- 8.02.02 Ground transportation to an alternative level of care when associated with an approved Hospital confinement; and

- 8.02.03 Ground transportation to a Member’s home will be covered when associated with an approved hospitalization or other confinement and the Member’s Condition requires the skill of medically trained personnel. Transportation is not covered when the skill of medically trained personnel is not required and the Member can be safely transferred (or transported) by other means;
- 8.02.04 Air Ambulance transportation is covered only when the point of pick-up is inaccessible by land or when distance or other obstacles are involved in transporting the Member to the nearest emergency facility equipped to adequately treat the Medical Condition.
- 8.03 **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.
- 8.04 **Bariatric Surgery Services (limited to JHS Centers of Excellence).** Treatment of control of clinically severe (Morbid Obesity):
 - 8.04.01 Bariatric Surgery Service. Benefits for medical and surgical services for the treatment or control of clinically severe (morbid) obesity as defined below may be covered if an individual meets such criteria; and 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. (See Section 10.02 for Limitations).
- 8.05 **Cardiac Rehabilitation.** Cardiac rehabilitation is covered for the following conditions: 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 your SBC for additional information regarding Copayments and Limitations.
- 8.06 **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.
- 8.07 **Clinical Trials:** Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:
 - 8.07.01 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.
 - 8.07.02 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.
 - 8.07.03 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.
 - 8.07.04 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.

- 8.07.05 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.
- 8.07.06 Routine costs for clinical trials do not include:
- a) the Experimental or Investigational service or item. The only exceptions to this are:
 - 1) certain Category B devices.
 - 2) certain promising interventions for patients with terminal illnesses.
 - 3) 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.
- 8.07.07 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:
 - 1) National Institutes of Health ("NIH"). (Includes National Cancer Institute.)
 - 2) Centers for Disease Control and Prevention.
 - 3) Agency for Healthcare Research and Quality.
 - 4) Centers for Medicare and Medicaid Services.
 - 5) A cooperative group or center of any of the entities described above or the Department of Defense ("DOD") or the Veteran's Administration.
 - 6) A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
 - 7) 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:

- i. Comparable to the system of peer review of studies and investigations used by the NIH.
 - ii. 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.

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

8.08.01 Acute nephritis;

8.08.02 Nephrosis;

8.08.03 Cardiac decompensation;

8.08.04 Eclampsia (toxemia with convulsions);

8.08.05 Ectopic pregnancy;

8.08.06 Uncontrolled vomiting requiring fluid replacement;

8.08.07 Missed abortion (i.e., fetal death without spontaneous abortion);

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

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

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

8.10 **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.

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.

- 8.11 **Diabetic Supplies.** Insulin, insulin syringes, alcohol swabs, lancets, and test strips are covered under the Prescription Drug Benefit subject to applicable Copayments.
- 8.12 **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.
 - 8.12.01 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.
 - 8.12.02 Coverage is subject to applicable Copayment and coverage limitation as outlined in the SBC.
- 8.13 **Diagnostic 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 Participating Physician as part of the diagnosis and/or treatment of a covered illness or injury or as preventive health care services.
- 8.14 **Diagnostic testing and treatment** related to Attention Deficit Hyperactivity Disorder ("ADHD").
- 8.15 **Dialysis Services.** Dialysis services including equipment, training and medical supplies, are covered when provided at an AvMed approved or contracted facility, by AvMed 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.
- 8.16 **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.
- 8.17 **Durable Medical Equipment and Orthotic Appliances.**
 - 8.17.01 Durable Medical Equipment. The Plan provides benefits, when Medically Necessary, for the purchase or rental of such Durable Medical Equipment that:
 - a) Can withstand repeated use (i.e. could normally be rented and used by successive patients);
 - b) Is primarily and customarily used to serve a medical purpose;
 - c) Generally is not useful to a person in the absence of illness or injury; and
 - d) Is appropriate for use in a patient's home.

- e) Durable Medical Equipment includes but is not limited to: hospital beds, walkers, crutches, wheelchairs, apnea monitors, oxygen and its administration, fetal heart rate monitors, external cardiac defibrillators, vacuum assisted closure devices, and insulin pumps. 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 your SBC for any Copayments, Part X, Section 10.06 for Limitations, and Part XI, Section 11.14 for Exclusions).
- 8.17.02 **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:
 - 1) Rigid and semi-rigid custom fabricated orthoses;
 - 2) Semi-rigid prefabricated and flexible orthoses; and
 - 3) Rigid prefabricated orthoses including preparation, fitting and basic additions such as bars and joints.
 - b) 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. (See Part XI for Exclusions).
- 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. The Plan may elect to transfer the Participant to a Participating Provider after the Participant's condition has been stabilized and as soon as it's medically appropriate to do so.
- 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 Member Engagement Center to request a copy. (See Part XI, Section 11.21 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 Participant's 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 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 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.** Home Health Care Services are covered when ordered by and under the direction of the Participant's Attending Physician. Physical, occupational, respiratory or speech therapy services provided in the home are limited as noted in Section 10.09. Homemaker or other Custodial Care services are not covered. (See Part XI for Exclusions).
- 8.23 **Hospice Services.** Services are available from an AvMed affiliated Hospice organization for a Participant whose Participating Physician has determined the Participant's illness will result in a remaining life span of twelve (12) months or less. (See Part X, Section 10.10 for Limitations).
- 8.24 **Hospital Care: Inpatient.** All Hospital inpatient services received at participating Hospitals are provided when prescribed by Participating Physicians and pre-authorized by AvMed. Inpatient Services include semi-private room and board, birthing rooms, newborn nursery care, nursing care, meals and special diets when Medically Necessary, use of operating 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.** Infertility coverage is limited to diagnostic testing and procedures performed specifically to determine the cause of infertility. (Subject to the Limitations as outlined in Section 10.12) 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.
- 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 Statutes 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.** 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) prostheses and physical complications during all stages of mastectomy including lymphedemas. 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 pre-authorization of services as applicable to other surgical procedures or hospitalizations under the Plan. (See Section 10.03 for Limitations). 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 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 **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. ELIGIBILITY), 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.

- 8.32 **Obstetrical and Gynecological Care.** An annual gynecological examination and Medically Necessary follow-up care detected at that visit are available without the need for a 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:
- 8.32.01 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);
 - 8.32.02 The does not need to obtain authorization from AvMed to prescribe a Hospital stay of this length;
 - 8.32.03 The Plan will cover an extended stay, if Medically Necessary; however, the Physician or Hospital must pre-certify the extended stay.
 - 8.32.04 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 and all other Plan limits and requirements.
- 8.33 **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.
- 8.34 **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.
- 8.35 **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, following discharge from a Hospital, for a condition that cannot be adequately treated with Home Health Care Services or on an ambulatory basis. (See Part X, Section 10.15 for Limitations, and 10.18 for Skilled Nursing Facility).
- 8.36 **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.

- 8.37 **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, click Elite Network, MDC Select Network, or MDC Jackson First HMO Network. 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.
- 8.38 **Participants are entitled to receive the Covered Services and benefits** only as herein specified and appropriately prescribed or directed by Participating Physicians. The Covered Services and benefits listed in the Schedule of Basic Benefits are available only from Participating Providers and, except for Emergency Medical Services and Care, the Plan shall have no liability or obligation whatsoever on account of services or benefits sought or received by any Participant from any Non-Participating Physician, Health Professional, Hospital or Other Health Care Facility, or other person, institution or organization, unless prior arrangements have been made for the Participant and confirmed by written referral or authorization from AvMed.
- 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 2.51 for the definition of Maximum Allowable Payment).
- 8.40 **Physician Care: Inpatient.** All Medical Services rendered by Participating 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 Participating 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 Participating Physicians and other Health Professionals, as requested or directed by the Primary Care Physician, are covered when provided at Medical Offices, 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.

- 8.42 **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 shown in your SBC and Prescription Drug Benefit Summary.
- 8.43 **Prosthetic Devices.** The Plan provides benefits, when Medically Necessary, for Prosthetic devices. Coverage for Prosthetic devices is limited to artificial limbs, artificial joints, and ocular prostheses. Coverage includes the initial purchase, fitting, or adjustment. Replacement is covered only when Medically Necessary due to a change in bodily configuration. The initial Prosthetic device following a covered mastectomy is also covered. Replacement of cataract lenses is covered only if there is a change in prescription which cannot be accommodated by eyeglasses. Prosthetic Devices for Deluxe, Myo-electric and electronic Prosthetic devices are not covered. (See your SBC for any Copayments, and Part XI, Section 11.36 for Exclusions).
- 8.44 **Rehabilitative Physical, Occupational, Respiratory or Speech Therapy.** Physical, occupational, respiratory or speech therapy provided in the outpatient or home care setting is covered for acute conditions for which therapy can be expected to result in significant improvement. Rehabilitation services for the acute phase of a chronic condition are covered only if, in the judgment of AvMed, such services are Medically Necessary and will result in significant improvement of a Participant’s condition through short-term therapy. Coverage of outpatient short-term and Rehabilitation Services is limited to sixty (60) visits per calendar year for all services combined. Therapy is covered for the treatment of Autism Spectrum Disorder, subject to Section 8.10 and 10.08. Long-term physical therapy, occupational therapy, speech therapy, rehabilitation, or other treatment of chronic conditions is not covered.
- 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 With prior notice to AvMed, the Participant may obtain the second medical opinion from any Participating or Non-Participating Physician, chosen by the Participant, who is within AvMed’s Service Area. 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 40% of the Maximum Allowable Payment for the second medical opinion.
- 8.45.02 Any tests that may be required to render the second medical opinion must be arranged by AvMed and performed by Participating Providers. 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**, 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.
 - 1) Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy. Human blood precursor cells may be obtained 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; or
 - i) lung - whole single or whole bilateral
- 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 2.80 will be covered by the Plan. See your 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 days lifetime maximum benefit. (See Part X, Section 10.21 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:
 - 9.04.01 be a Covered Retiree, who lives inside the Service Area, as applicable; or
 - 9.04.02 be a Covered Dependent under the Plan, of a Covered Employee or a Covered Retiree who lives inside the Services Area; and
 - 9.04.02 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, and if school is outside Florida, proof is required.
 - 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 a 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 letter. 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** covered when Medically Necessary.
- 10.02 **Bariatric Surgery Services** is limited to JHS Centers of Excellence. (See Part XI, Section 11.05 for Exclusions).
- 10.03 **Breast Reconstruction and Breast Prostheses:**

- 10.03.01 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 replacement bras within each 12 month time period. (See Section 11.06 for Exclusions).
- 10.04 **Cardiac rehabilitation** is covered for the following conditions and is limited to thirty-six (36) visits per calendar year:
- 10.04.01 Acute myocardial infarction
 - 10.04.02 Percutaneous transluminal coronary angioplasty (PTCA)
 - 10.04.03 Repair or replacement of heart valves
 - 10.04.04 Coronary artery bypass graft (CABG), or
 - 10.04.05 Heart transplant
- 10.05 **Chiropractic (Spinal manipulations)** will be covered only when Medically Necessary and prescribed by a Participating Physician or by self-referral to a Participating Physician.
- 10.06 **Durable Medical Equipment** includes but is not limited to: hospital beds, walkers, crutches, wheelchairs, apnea monitors, oxygen and its administration, fetal heart rate monitors, external cardiac defibrillator vests, vacuum assisted closure devices, and insulin pumps.
- 10.06.01 Orthotic appliances are limited to the following:
- a) Non-foot orthoses – only the following non-foot orthoses are covered:
 - 1) Rigid and semi-rigid custom fabricated orthoses;
 - 2) Semi-rigid prefabricated and flexible orthoses; and
 - 3) Rigid prefabricated orthoses including preparation, fitting and basic additions such as bars and joints.
 - b) 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 Participant will not be covered. (See Part XI, 11.14 for Exclusions).
- 10.07 **Eye Exam for Children.** Eye exam for children is limited to one exam per year to determine the need for sight correction. See 11.19 for Exclusions.
- 10.08 **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. (See Part II, Section 2.37 for the Definition).
- 10.09 **Home Health Care.** Home health care requires an approved treatment plan.
- 10.10 **Hospice Care** is limited to 360 days per Participant lifetime maximum. Physician certification required.

- 10.11 **Hyperbaric oxygen treatments** 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.
- 10.12 **Infertility** coverage is limited to diagnostic testing and procedures performed specifically to determine the cause of infertility. Infertility treatment is limited to one sequence per Participants lifetime for the following: sperm count, endometrial biopsy, hysterosalpingography (HSG), and diagnostic laparoscopy. See 11.28 for Exclusions.
- 10.13 **Licensed dietitians/nutritionists** for treatment of obesity control shall be limited to three outpatient visits per calendar year and each visit requires a Copayment.
- 10.14 **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).
- 10.15 **Other Health Care Facility(ies).** All routine inpatient 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, following discharge from a Hospital, for a condition that cannot be adequately treated with Home Health Care Services or on an ambulatory basis.
- 10.16 **Rehabilitative physical, occupational, respiratory and speech therapy** have a combined limit of sixty (60) visits per calendar year.
- 10.17 **Skilled Nursing Care.** Skilled nursing care is limited to sixty (60) days per calendar year. Prior Authorization is required.
- 10.18 **Surgical or non-surgical procedures,** which are undertaken to improve or otherwise modify the Participant's external appearance, shall be limited to reconstructive surgery to correct and repair a functional disorder as a result of a disease, injury, or congenital defect or initial implanted prosthesis and reconstructive surgery incident to a mastectomy for cancer of the breast.
- 10.19 **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 is a benefit available only when the transplant is authorized at one of AvMed's transplant contracted facilities nationwide.
- 10.20 **Ventilator Dependent Care** is limited to 100 days lifetime maximum benefit.
- 10.21 **Wigs/Cranial Prosthesis** is 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 **Acupuncture,** biofeedback, hypnotherapy, massage therapy, sleep therapy, sex therapy, behavioral training, cognitive therapy, and vocational rehabilitation.
- 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); services 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 **Any sickness or injury** for which the Participant is paid benefits, or may be paid benefits if claimed, if the Participant is covered or required to be covered by Workers' Compensation. In addition, if the Participant enters into a settlement giving up rights to recover past or future medical benefits under a Workers' Compensation law, AvMed shall not cover past or future Medical Services that are the subject of or related to that settlement. Furthermore, if the Participant is covered by a Worker's Compensation program that limits benefits if other than specified Health Care Providers are used and the Participant receives care or services from a Health Care Provider not specified by the program, AvMed shall not cover the balance of any costs remaining after the program has paid.
- 11.04 **Any treatment or service from a Non-Participating Provider**, except in the case of an emergency or when specifically, pre-authorized by AvMed.
- 11.05 **Bariatric Surgery Services.** (Gastric stapling, gastric bypass, gastric banding, gastric bubbles, and other procedures). The following items are specifically excluded:
- 11.05.01 Any Services performed at other facilities other than JHS Centers of Excellence.
 - 11.05.02 Medical and surgical services to alter the 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.
 - 11.05.03 Weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.
 - 11.05.04 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 the Covered Expenses.
 - 11.05.05 Ongoing visits other than establishing a program of obesity control.
- 11.06 **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.
- 11.07 **Complications of any non-covered service**, including the evaluation or treatment of any condition that arises as a complication of a non-covered service.
- 11.08 **Cosmetic Services.** Surgical or non-surgical procedures which are undertaken primarily to improve or otherwise modify the Participant's external 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. Also excluded are surgical excision or reformation of any sagging skin of any part of the body, including, but not limited to: the eyelids, face, neck, abdomen, arms, legs, or

buttocks; any services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body, including, but not limited to: the face, lips, jaw, chin, nose, ears, breasts, or genitals (including circumcision, except newborns for up to one year from date of birth); hair transplantation, chemical face peels or abrasion of the skin, electrolysis depilation, removal of tattooing; or any other surgical or non-surgical procedures which are primarily for cosmetic purposes or to create body symmetry. Additionally, all medical complications as a result of cosmetic, surgical or non-surgical procedures are excluded.

- 11.09 **Cosmetics, dietary supplements**, health or beauty aids, and nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- 11.10 **Custodial Care.**
- 11.11 **Dental Care** for any condition except:
 - 11.11.01 When such services are for the treatment of trauma related fractures of the jaw or facial bones or for the treatment of tumors;
 - 11.11.02 Reconstructive jaw surgery for the treatment of deformities that are present and apparent at birth;
 - 11.11.03 Full mouth extraction when required before radiation therapy; or
 - 11.11.04 Treatment following injury to sound natural teeth started within six months of accident.
- 11.12 **Diagnostic testing and treatment** related to mental retardation or deficiency, learning disabilities, and behavioral problems. Expenses for remedial or special education, counseling, or therapy including evaluation and treatment of the above listed conditions or behavioral training whether or not associated with manifest mental disorders or other disturbances.
- 11.13 **Donor Services.** The Medical Services and Hospital Services for a donor or prospective donor who is covered under this Plan or another Plan sponsored by this Plan Sponsor when the recipient of an organ transplant is not covered by this Plan Sponsor. Coverage is provided for costs associated with the bone marrow donor-patients to the same extent as the covered recipient. The reasonable costs of searching for the bone marrow donor is limited to family Participants and the National Bone Marrow Donor Program. Post-transplant donor complications will not be covered.
- 11.14 **Durable Medical Equipment (DME)** items that are not covered include, but are not limited to the following:
 - 11.14.01 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;
 - 11.14.02 bath related items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, handheld showers, paraffin baths, bath mats, and spas;
 - 11.14.03 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 2- person transfer), and auto tilt chairs;
 - 11.14.04 fixtures to real property: ceiling lifts and wheelchair ramps;
 - 11.14.05 car/van modifications;

- 11.14.06 air quality items: air conditioners, room humidifiers, vaporizers, air purifiers and electrostatic machines;
- 11.14.07 blood/injection related items: blood pressure cuffs, centrifuges, nova pens and needleless injectors; and
- 11.14.08 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.
- 11.14.09 The replacement of Durable Medical Equipment solely because it is old or used is excluded.
- 11.15 **Except for ostomy supplies**, urinary catheter bags and certain wound care supplies, medical supplies including, but not limited to Thromboembolic/Support hose and all other bandages are not covered.
- 11.16 **Exercise programs**, gym memberships, or exercise equipment of any kind, including, but not limited to: exercise bicycles, treadmills, stairmasters, rowing machines, free weights or resistance equipment. Also excluded are massage devices, portable whirlpool pumps, hot tubs, jacuzzis, sauna baths, swimming pools and similar equipment.
- 11.17 **Expenses for supplies**, care, treatment, or surgery that is not Medically Necessary.
- 11.18 **Experimental and/or Investigational** procedures, except for bone marrow transplants, as approved per Florida Administrative Code, Section 59B-12.001. For the purposes of this Plan, a medication, treatment, device, surgery or procedure may be determined to be Experimental and/or Investigational if any of the following applies:
 - 11.18.01 The FDA has not granted the approval for general use;
 - 11.18.02 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;
 - 11.18.03 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 a similar condition; or
 - 11.18.04 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 dosages, toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question.
- 11.19 **Eye care** including:
 - 11.19.01 Eye examinations for Participants 18 years of age or older for the purpose of determining the need for sight correction (such as eye glasses or contact lenses);
 - 11.19.02 Training or orthoptics, including eye exercises; or
 - 11.19.03 Radial keratotomy, refractory keratoplasty, Lasik surgery or any other corneal surgical procedure to correct refractive error.

- 11.20 **Foot Supports** are not covered. These include orthopedic or specialty shoes, shoe build-ups, shoe orthotics, foot orthotics, shoe braces, and shoe supports. Also excluded is routine foot care, including trimming of corns, calluses, and nails.
- 11.21 **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 the details.
- 11.22 **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.
- 11.23 **Hearing examinations** for Participants 18 years of age or older for the purpose of determining the need for hearing correction.
- 11.24 **Home monitoring devices** and measuring devices (other than apnea monitors and Holter monitors), and any other equipment or devices for use outside the Hospital.
- 11.25 **Hospital Exclusion.** If a Participant elect to receive Hospital care from a Non-Participating Provider or a non-participating Hospital, then coverage is excluded for the entire episode of care, except when the admission was due to an emergency or with the prior written authorization of AvMed.
- 11.26 **Hospital Services** that are associated with excluded surgery or Dental Care.
- 11.27 **Immunizations and medications** for the purpose of foreign travel or employment.
- 11.28 **Infertility Treatment.** Artificial Insemination, In-vitro fertilizations, GIFT, ZIFT, and other infertility treatments are not covered.
- 11.29 **Mandibular and maxillary osteotomies** except when Medically Necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.
- 11.30 **Medical care or surgery not authorized** by a Participating Provider, except for Emergency Medical Services and Care, or not within the benefits covered by AvMed.
- 11.31 **Over-the-Counter Medications.**
- 11.32 **Personal comfort items** not Medically Necessary for proper medical care as part of the therapeutic plan to treat or arrest the progression of an illness or injury. This Exclusion includes, but is not limited to: wigs (including partial hair pieces, weaves, and toupees) except following treatment of cancer or a brain tumor, personal care kits, guest meals and accommodations, maid services, televisions/radios, telephone charges, photographs, complimentary meals, birth announcements, take home supplies, travel expenses (other than Medically Necessary ambulance services), air conditioners, humidifiers, dehumidifiers, and air purifiers or filters.
- 11.33 **Physical examinations or tests**, such as premarital blood tests or tests for continuing employment, education, licensing, or insurance or that are otherwise required by a third party.
- 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 Duty Nursing Services.**

- 11.36 **Prosthetic Devices** for Deluxe, Myo-electric and electronic Prosthetic devices are not covered.
- 11.37 **Removal of warts, moles, skin tags, lipomas, keloids, scars,** and other benign skin lesions is not covered, even with a recommendation or prescription by a Physician, unless AvMed determines that there is sufficient justification for removal.
- 11.38 **Reversal of Sterilization Procedures.**
- 11.39 **Services associated with autopsy or postmortem examinations,** including the autopsy.
- 11.40 **Services related to the diagnosis/treatment of temporomandibular joint (TMJ) dysfunction** except when Medically Necessary; all dental treatment for TMJ.
- 11.41 **Sexual Dysfunction** benefits are not available for sex therapy and drug therapies except certain drugs approved by the Plan and only to treat erectile dysfunction due to an organic cause.
- 11.42 **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.
- 11.43 **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.
- 11.44 **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.
- 11.45 **Termination of pregnancy** unless deemed Medically Necessary by the Medical Director, subject to applicable State and Federal laws.
- 11.46 **Transplant Services.** Transplant services and procedures provided by or at facilities that are not AvMed contracted Transplant Centers. See 8.46 for Covered Benefit details, and 10.20 for Limitation details.
- 11.47 **Travel expenses** including expenses for ambulance services to and from a Physician or Hospital except for emergency care.
- 11.48 **Ventilator Dependent Care** in excess of 100 calendar day lifetime maximum benefit.
- 11.49 **Vocational Rehabilitation, Pulmonary Rehabilitation, or Long Term Rehabilitation.**

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 the Claim. Information received after one (1) year from the date 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 Group Plan or the Plan will assume that the Participant has both Parts A and B.

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:
- 13.04.01 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
 - 13.04.02 Cooperate with the Plan and do whatever is necessary to secure the Plan's rights of subrogation and/or reimbursement under this SPD; and
 - 13.04.03 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
 - 13.04.04 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
 - 13.04.05 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 Participating Physicians. Participating 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 refuse to accept the medical treatment or procedure recommended by the Participating Physician and if, in the judgment of the Participating Physician, no professionally acceptable alternative exists or if an alternative treatment does exist but is not recommended by the Participating Physician, the 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 AvMed 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 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.

- 15.07.06 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 purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
 - 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 Circumstances not reasonably within the control of AvMed or the County, such as complete or partial destruction of facilities, an act of God, war, riot, civil insurrection, disability of a significant part of a Hospital or participating medical personnel or similar causes, if the rendering of Medical and Hospital Services provided under this Plan is delayed or rendered impractical, neither AvMed, Participating Providers, nor any Physician shall have any liability or obligation on account of such delay or failure to provide services; however, AvMed shall make a good faith effort to arrange for the timely provision of Covered Services during such event

16.02 **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. Retroactive adjustments in coverage, for clerical errors or otherwise will only be done for up to a sixty (60) day period from the date of notification. Refunds of administrative service fees are done for up to a sixty (60) day period from the date of notification. Refunds of administrative service fees are limited to a total of sixty (60) days from the date of notification of the event, provided there are no Claims incurred subsequent to the effective date of such event.

- 16.03 **Gender.** Whenever used, the singular shall include the plural, and the plural the singular, and the use of any gender shall include all genders.
- 16.04 **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.
- 16.05 **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.
- 16.06 **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.
- 16.07 **Waiver.** A Claim which has not been timely filed with the Plan within one (1) year of date of service shall be considered waived.