# Summary Plan Description

# of the

# Medicare Eligible Retiree High Option with Prescription Medication Coverage for the

# Miami-Dade County Group Health Plan

# Contract No. 00196

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# I. INTRODUCTION

## Important Information

This is not an insured benefit plan. The benefits described in this booklet or any rider attached hereto are self-insured by Miami-Dade County (MDC) which is responsible for their payment. AvMed Health Plans provides claim administration services to the Plan, but AvMed does not insure the benefits described.

The effective date of the benefits described on the following pages is January 1, 2025.

**Explanation of Terms.** You will find terms starting with capital letters throughout your Summary Plan Description. To help you understand your benefits, most of these terms are defined in the Definitions section of your Summary Plan Description.

**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

As used in this Summary Plan Description, each of the following terms shall have the meaning indicated: For further definitions, go to www.medicare.gov, or www.healthcare.gov to review the glossary provided as a result of the Affordable Care Act.

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

2.05 **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.

2.06 **Bed and Board** means all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

2.07 **Beneficiary** means a person who has health care insurance through the Medicare or Medicaid programs.

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

2.09 **Claimant** means a Member or a Member's authorized representative acting on behalf of the Member. AvMed may establish procedures for determining whether an individual is authorized to act on behalf of the Member. If the Claim is an Urgent Care or Pre-Service Claim, a Health Professional, with knowledge of the Member's medical Condition, shall be authorized to act as the Member's representative for notification of approvals.

2.10 **Coinsurance** means an amount you may be required to pay as your share of the cost for services after you pay any Deductible. Coinsurance is usually a percentage (for example, 20%).

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

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

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

2.14 **County** means **Miami-Dade County**.

2.15 **Covered Benefits** or **Covered Services** means those Medical Services to which a Member is entitled under the term of the Plan.

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

2.17 **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.

2.18 **Custodial Services** means any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical Condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical Condition; they are intended to provide care while the patient cannot care for himself or herself.

2.18.01 Custodial Services include but are not limited to:

a. services related to watching or protecting a person; services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self-administered, and services not required to be performed by trained or skilled medical or paramedical personnel.

2.19 **Dependent** means a spouse, Domestic Partner, child of a Domestic Partner or dependent child of a Medicare eligible retiree age 65 or over.

2.20 **Domestic Partner 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:

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

2.20.02 Are not related to the other by blood;

2.20.03 Are at least eighteen years of age;

2.20.04 Are mentally competent to consent to a contract;

2.20.05 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;

2.20.06 Have filed a Domestic Partnership registration with the Consumer Services Department.

2.20.07 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

2.20.08 Reside in the same primary residence.

2.21 **Durable Medical Equipment (DME), Orthotics, and/or Prosthetics.** Coverage for DME, Orthotics and Prosthetics is limited as outlined, and subject to specific Exclusions. 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.

2.22 **Emergency Medical Condition** means a medical Condition, including a mental health Condition, or a 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:

2.22.01 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.

2.22.02 Serious impairment to bodily functions.

2.22.03 Serious dysfunction of any bodily organ or part.

2.22.04 The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor; or the final diagnosis, whichever reasonably indicated an emergency medical Condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

2.22.05 Examples of Emergency Medical Conditions include, but are not limited to:

a. heart attack, stroke, massive internal or external bleeding, fractured limbs, or severe trauma.

2.23 **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.

2.24 **Employee.** The term Employee means a retired employee.

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

2.26 **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:

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

2.26.02 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

2.26.03 There is no consensus among practicing Physician 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

2.26.04 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 if the PHSA are satisfied.

2.27 **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:

2.27.01 A Hospital;

2.27.02 A Hospital outpatient department;

2.27.03 An ambulatory surgical center

2.28 **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.

2.29 **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.

2.30 **Home Health Care Services** means services that are provided for a Member 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.

2.31 **Hospice Care Program** means a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families; or a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness; or a program for persons who have a Terminal Illness and for the families of those persons.

2.32 **Hospice Care Services** means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

2.33 **Hospice Facility** means an institution or part of it which:

2.33.01 Primarily provides care for Terminally Ill patients;

2.33.02 Is accredited by the National Hospice Organization;

2.33.03 Meets standards established by AvMed; and

2.33.04 Fulfills any licensing requirements of the state or locality in which it operates.

2.34 **Hospital** means an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of physicians; and provides 24-hour service by Registered Graduate Nurses.

2.34.01 An institution which: qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as hospital by the Joint Commission on the Accreditation of healthcare Organizations; or

2.34.02 An institution which: specializes in the treatment of Mental Health and Substance Abuse or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency. The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

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

2.35.01 Generally and customarily provided by acute care general Hospitals within the area;

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

2.35.03 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.

2.36 **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: intra-articular, intracavernous, intramuscular, intraocular, intrathecal, intravenous or subcutaneous injection; or intravenous infusion. Medications intended to be injected or infused by a Health Professional are generally covered as a medical benefit. Pre-authorization is required for Injectable Medications.

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

2.38 **Maximum Allowable Payment** means the maximum amount that AvMed will pay for any covered service rendered by a Non-Participating Provider or supplier of services, medications or supplies.

2.39 **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 Member's illness or injury, and which is:

2.39.01 Consistent with the symptom, diagnosis, and treatment of the Member's Condition;

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

2.39.03 In accordance with standards of acceptable community practice;

2.39.04 Not primarily intended for the personal comfort or convenience of the Member, the Member's family, the Physician, or other health care provider;

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

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

2.39.07 Not Experimental and/or Investigational.

2.40 **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:

2.40.01 Generally and customarily provided in the Service Area;

2.40.02 Performed, prescribed, or directed by Participating Providers; and

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

2.41 **Medicare** means the term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

2.42 **Medicare Part A** (Hospital Insurance) covers inpatient hospital stays, care in a Skilled Nursing Facility, Hospice Care, and some Home Health care.

2.43 **Medicare Part B** (Medical Insurance) covers certain doctor' services, outpatient care, medical supplies, and preventive services.

2.44 **Member** means any retiree or Dependent.

2.45 **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 rehabilitative services.

2.46 **Outpatient Hospital Care** means medical or surgical care you get from a hospital when your doctor hasn't written an order to admit you to the hospital as an inpatient. Outpatient hospital care may include emergency department services, observation services, outpatient surgery, lab tests, or X-rays.

2.47 **Plan** means the Miami-Dade County Group Health Plan sponsored by the County to provide Covered Medical Services to Members.

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

2.49 **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "Providers" also include hospitals and other health care facilities.

2.50 **Rehabilitation Services** means health care services that help you keep, get back, or improve skills and functioning for daily living that you've lost or have been impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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

2.51.01 Was relied upon in making the benefit determination;

2.51.02 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;

2.51.03 Demonstrated compliance with the administrative process; and

2.51.04 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.

2.52 **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.

2.53 **Skilled Nursing Facility** means a licensed institution (other than a Hospital, as defined) which specializes in physical rehabilitation on an inpatient basis; or skilled nursing and medical care on an inpatient basis; but only if that institution: maintains on the premises all facilities necessary for medical treatment provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

2.54 **Summary Plan Description (SPD)** describes a variety of benefits such as medical, dental, life, long term disability, accidental death and dismemberment, group travel accident, flexible spending accounts and other voluntary benefits for eligible state and local government employees, retirees, and their eligible dependents.

2.55 **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.

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

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

2.58 **Urgent Care Claim** means any Claim for medical care or treatment that could seriously jeopardize the Member's life or health or the Member's ability to regain maximum function or, in the opinion of a Physician with knowledge of the Member's medical Condition, would subject the Member 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 Member's medical Condition determines that the Claim is an Urgent Care Claim, it shall be deemed as such.

2.59 **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.

## III. HOW TO FILE YOUR CLAIM

3.01 Your medical providers should send all Claims first to Medicare, as this Plan will provide benefits after Medicare has determined its coverage. In most cases, AvMed will be notified directly when Medicare processes your Claim and you will not need to provide AvMed with the Explanation of Medicare Benefits forms you receive. Should AvMed not receive this information directly from the Medicare third party payer, then you will need to submit your Explanation of Medicare Benefits form to us.

3.02 For those services covered under this Plan but not covered by Medicare, you should promptly file all Claims for reimbursement with AvMed at P.O. Box 569000, Miami, FL 33256. Should you need a claim form, you may request one directly from AvMed by calling 1-800-682-8633.

3.03 **Please note:** No Claim will be paid on expenses which are not approved by Medicare except as stated in your Benefit Summary.

## IV. ACCIDENT & HEALTH PROVISIONS: NOTICE OF CLAIM & PROOF OF LOSS

4.01 Written notice of Claim must be given to AvMed within 30 days after the occurrence or start of the loss on which Claim is based. Written proof of loss must be given to AvMed within 90 days after the date of the loss for which a Claim is made. If notice is not given in that time, the Claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

## V. ELIGIBILITY FOR RETIREE COVERAGE

5.01 You will become eligible for coverage on the date you retire if you are in a Class of Eligible Retirees and are enrolled for medical benefits as of your retirement date. If you are eligible for coverage and change to another County Plan during the retiree open enrollment period, coverage becomes effective on the renewal date of the Group Plan.

5.02 **Eligibility for Dependent Coverage.** Your Medicare eligible Dependent including Domestic Partner will become eligible for this coverage on the latest of:

5.02.01 The date you become eligible for coverage yourself, assuming your dependent or Domestic Partner had active medical coverage through your retirement date; or

5.02.02 The first of the month that the dependent or Domestic Partner turns age 65 (or becomes Medicare eligible); assuming the dependent or Domestic Partner was covered under another MDC medical plan the month prior to reaching Medicare eligibility.

5.02.03 The First of the month following a qualifying event (QE) providing timely receipt of the enrollment application.

5.03 **Classes of Eligible Retirees**

5.03.01 Each eligible Retiree is reported to AvMed by your former Employer.

5.04 **Effective Date of Your Coverage**

5.04.01 Your coverage will become effective:

a. For new retirees, coverage cannot be activated until your first month's premium is received by your employer along with a signed election form. To be covered for these benefits, you must elect the coverage for yourself no later than 30 days from your retirement date. Coverage will be retroactive to the date your coverage as an active employee expired.

b. For retirees currently enrolled in another MDC retiree medical plan, the first of the month that you turn age 65, assuming a timely election is made.

5.04.02 You will not be enrolled for medical coverage if you do not elect to enroll within 30 days of your eligibility date, unless you qualify under the section of this Summary Plan Description entitled "Special Enrollment Rights under the Health Insurance Portability & Accountability Act (HIPAA)."

5.05 **Premiums.** Retirees pay the full cost of their (and dependent's) medical premiums.

5.06 **Dependent Coverage.** For your Dependents including a Domestic Partner to be covered, you will have to pay all the cost of Dependent or Domestic Partner coverage.

5.07 **Effective Date of Dependent Coverage**. The effective date of benefits for your eligible dependent will be on the date your retiree medical coverage becomes effective. If you are adding a newly acquired dependent including a Domestic Partner, an election must be made within forty-five (45) days of the qualifying event. Coverage is effective the first of the month following your employer's receipt of your written notification.

5.08 **Exception for Newborns.** Any Dependent child born while you are covered for medical coverage will become covered for medical coverage on the date of his birth if you elect Dependent medical coverage no later than 60 days after birth. If you do not elect to cover your newborn child within such 60 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable. A newborn child of a Covered Dependent other than the spouse of the Covered Retiree (such coverage terminates 18 months after the birth of the newborn child). (See Also, Federal Requirement's, Eligibility for Coverage for Adopted Children).

## VI. COMPREHENSIVE MEDICAL BENEFITS

### Certification Requirements - For You and Your Dependents

Certain medications require prior authorization. Please refer to the formulary listed on www.avmed.org/mdc, go to Quick Links, and click on Preferred Medication Lists, or contact AvMed's Member Engagement Center at 1-800-682-8633, 24 hours a day, 7 days a week. In the event your physician prescribes a medication that requires prior authorization, the pharmacy will notify you and your physician will be asked to submit medical documentation to AvMed in support of his or her request.

**Please Note:** No Claim will be paid on expenses which are not approved by Medicare except as stated in your Benefit Summary.

**Covered Expenses.** The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes covered for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by AvMed. Any applicable Copayments, Deductibles or limits are shown in the Schedule.

6.01 Charges made for **reconstructive surgery following a mastectomy**; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) 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.

6.02 Charges made for **Foreign Travel Medical Emergency/Accident Services**, subject to the Individual Deductible and maximum lifetime benefit shown in The Schedule of Benefits, for claims incurred and handled as follows:

6.02.01 While traveling outside of the United States, you receive immediate Medically Necessary care for an Illness or Injury;

6.02.02 The medical emergency begins within 60 days of you or your Dependent leaving the United States;

6.02.03 The care would have been covered by Medicare if provided in the United States; and

6.02.04 Claims must be translated into English and all charges must be converted as of the date of service from the foreign currency to United States dollars.

6.03 Charges made by a **Hospital**, on its own behalf, for **Bed and Board** and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for bed and board which is more than the Bed and Board Limit shown in The Schedule of Benefits.

6.04 Charges for licensed **ambulance service** to or from the nearest Hospital where the needed medical care and treatment can be provided.

6.05 Charges made by a **Hospital**, on its own behalf, for **medical care and treatment** received as an **outpatient**.

6.06 Charges made by a **free-standing surgical facility**, on its own behalf for medical care and treatment.

6.07 Charges made on its own behalf, by an **Other Health Care Facility**, including a Skilled Nursing Facility, a Rehabilitation Hospital or a sub-acute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include the portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule of Benefits.

6.08 Charges made by a Hospital Emergency Room or an Urgent Care Center, for **medical care and treatment received as an outpatient for Emergency Services or emergency care**.

6.09 Charges made by a **Physician or a Psychologist for professional services**.

6.10 Charges made by a Nurse, other than a member of your family or your Dependent's family, for **professional nursing service**.

6.11 Charges made for **anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration**.

6.12 **Mammogram screenings** are covered in accordance with Florida Statues and the U.S. Preventive Task Force (USPSTF) preventive service recommendations once every 12 months for female participants age 50 and older. Diagnostic mammograms are covered when Medically Necessary.

6.13 Charges for an **inpatient Hospital stay following a mastectomy** will be covered for a period determined to be medically necessary by the Physician and in consultation with the patient. Post-surgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.

6.14 For charges for **hyperalimentation or Total Parenteral Nutrition (TPN)** for persons recovering from or preparing for surgery, however, benefits will not be paid for a period of longer than 3 months.

6.15 Charges made for an annual **Papanicolaou laboratory screening test**.

6.16 Charges made for an annual **prostate-specific antigen test (PSA)**.

6.17 Charges for appropriate **counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.**

6.18 Charges made for **laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.**

6.19 Charges made for visits for **routine preventive care** of a Dependent child during the first fifteen years of that Dependent child’s life, including immunizations.

6.20 Charges made for **medical diagnostic services to determine the cause of erectile dysfunction**. Penile implants are covered for an established medical Condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Penile implants are not covered as treatment of psychogenic erectile dysfunction.

6.21 **Surgical or nonsurgical treatment of TMJ Dysfunction e**xcluding appliances and orthodontia treatment.

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

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

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

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

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

6.23 **Acupuncture** covers up to 12 acupuncture treatments in 90 days for chronic low back pain. Medicare covers an additional 8 sessions if you show improvement. Maximum of 20 acupuncture treatments in a 12-month period.

6.24 **Clinical Trials**

6.24.01 Charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:

a) The cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;

b) The trial investigates a treatment for terminal cancer and:

i. the person has failed standard therapies for the disease

ii. cannot tolerate standard therapies for the disease; or

iii. no effective non experimental treatment for the disease exists;

c) The person meets all inclusion criteria for the clinical trial and is not treated "off-protocol";

d) The trial is approved by the Institutional Review Board of the institution administering the treatment; and

6.24.02 Routine patient services do **not include**, and reimbursement will not be provided for:

a) The investigational service or supply itself;

b) Services or supplies listed herein as Exclusions;

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

d) Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

6.25 **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 the 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 Exclusions for details.

6.26 **Genetic Testing**

6.26.01 Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

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

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

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

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

6.26.06 Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per contract year for both pre- and post-genetic testing.

6.27 **Internal Prosthetic/Medical Appliances**

6.28 **Home Health Services**

6.28.01 Charges made by a Home Health Care Agency for the following medical services and supplies provided under the terms of a Home Health Care Plan for the person named in that plan:

a) part time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse;

b) part time or intermittent services of a Home Health Aide;

c) physical, occupational, or speech therapy;

d) medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent that such charges would have been considered Covered Expenses had a person required confinement in the Hospital as a registered bed patient or confinement in a Skilled Nursing Facility;

e) Skilled nursing services, Private Duty Nursing services, physical therapy, occupational therapy and speech therapy provided in the home are subject to the Home Health Services benefit terms and limitations as shown in the Schedule

6.28.02 The following charges are **excluded**:

a) home health care visits during a calendar year, in excess of the Home Health Care Maximum shown in The Schedule. (To determine the benefits payable, each visit by an employee of a Home Health Care Agency will be considered one home health care visit and each 4 hours of Home Health Aide services will be considered one home health care visit.);

b) care or treatment which is not stated in the Home Health Care Plan;

c) the services of a person who is a member of your family or your Dependent's family or who normally lives in your home or your Dependent's home;

d) a period when a person is not under the continuing care of a Physician.

6.29 **Hospice Care Services**

6.29.01 Charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:

a) By a Hospice Facility for bed and board and Services and Supplies, except that, for any day of confinement in a private room, unless no semi-private room is available. Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Daily Limit shown in The Schedule unless no semi-private room is available;

b) By a Hospice Facility for services provided on an outpatient basis;

c) By a Physician for professional services;

d) By a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;

e) For pain relief treatment, including drugs, medicines and medical supplies.

6.29.02 By an Other Health Care Facility for:

a) Part-time or intermittent nursing care by or under the supervision of a Nurse;

b) Part-time or intermittent services of an Other Health Care Professional;

c) Physical, occupational and speech therapy;

d) Medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the Plan if the person had remained or been Confined in a Hospital or Hospice Facility.

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

a) For the services of a person who is a member of your family or your Dependent family or who normally resides in your house or your Dependent's house;

b) For any period when you or your Dependent is not under the care of a Physician;

c) For services or supplies not listed in the Hospice Care Program;

d) For any curative or life-prolonging procedures;

e) To the extent that any other benefits are payable for those expenses under the Plan;

f) For services or supplies that are primarily to aid you or your Dependent in daily living.

6.30 **Injectable Drugs.** Medicare Part B (Medical Insurance) generally covers care you get in a hospital outpatient setting through an IV (intravenous infusion).

6.31 **Mental Health and Substance Abuse Services**

6.31.01 Charges made by a facility licensed to furnish mental health services, on its own behalf, for care and treatment of mental illness.

6.31.02 Charges made by a facility licensed to furnish treatment of alcohol and drug abuse, on its own behalf, for care and treatment of Substance Abuse.

6.32 **Mental Health and Substance Abuse Services Exclusions.** The following are specifically **excluded** from Mental Health and Substance Abuse Services:

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

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

6.32.03 Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.

6.32.04 Counseling for activities of an educational nature.

6.32.05 Counseling for borderline intellectual functioning.

6.32.06 Counseling for occupational problems.

6.32.07 Counseling related to consciousness raising.

6.32.08 Vocational or religious counseling.

6.32.09 I.Q. testing.

6.32.10 Custodial care, including but not limited to geriatric day care.

6.32.11 Psychological testing on children requested by or for a school system.

6.32.12 Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

6.33 **Nutritional Evaluation**

6.33.01 Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

6.34 **Durable Medical Equipment**

6.34.01 Charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a Medicare contracted vendor for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

6.34.02 Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, dialysis machines, and expendable and non-reusable items

essential to the effective use of the equipment. Such supplies include those drugs and biologicals that must be put directly into the equipment in order to achieve the therapeutic benefit.

6.34.03 Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

a) Bed Related Items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.

b) Bath Related Items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.

c) Chairs, Lifts and Standing Devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.

d) Fixtures to Real Property: ceiling lifts and wheelchair ramps.

e) Car/Van Modifications.

f) Air Quality Items: room humidifiers, vaporizers, air purifiers and electrostatic machines.

g) Blood/Injection Related Items: blood pressure cuffs, centrifuges, nova pens and needle less injectors.

h) 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 and diathermy machines.

## 6.35 External Prosthetic Appliances and Devices

6.35.01 Charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician. External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

## 6.36 Prostheses/Prosthetic Appliances and Devices

6.36.01 Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

a) Basic limb prostheses;

b) Terminal devices such as hands or hooks; and

c) Speech prostheses.

## 6.37 Orthoses and Orthotic Devices

6.37.01 Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

a) Non-foot orthoses – only the following non-foot orthoses are covered:
   i. Rigid and semi rigid custom fabricated orthoses,
   ii. Semi rigid prefabricated and flexible orthoses; and
   iii. Rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.

b) Custom foot orthoses – custom foot orthoses are only covered as follows:
   i. For persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
   ii. When the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
   iii. When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
   iv. For persons with neurologic or neuromuscular Condition (E.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

c) The following are specifically excluded orthoses and orthotic devices:
   i. Prefabricated foot orthoses;
   ii. Cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
   iii. Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
   iv. Orthoses primarily used for cosmetic rather than functional reasons; and
   v. Orthoses primarily for improved athletic performance or sports participation.

6.37.02 **Braces.** A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part

a) The following braces are specifically **excluded**: Copes scoliosis braces.

6.37.03 **Splints.** A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts

a) Coverage for replacement of external prosthetic appliances and devices is **limited** to the following:
   i. Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
   ii. Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
   iii. Coverage for replacement is **limited** as follows:
      1) No more than once every 24 months for persons 19 years of age and older;

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

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

b) The following are specifically excluded external prosthetic appliances and devices:

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

ii. Myoelectric prostheses peripheral nerve stimulators.

**Please note:** No claim will be paid on expenses which are not approved by Medicare except as stated in your Benefit Summary.

6.38 **Short-Term Rehabilitative Therapy Services.** Charges made for Short-Term Rehabilitative Therapy which is a part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate inpatient or outpatient setting. Also included are services that are provided by a chiropractic Physician when provided in an outpatient setting. Services of a chiropractic Physician include the management of neuromusculoskeletal Conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

6.38.01 The following limitations apply to Short-Term Rehabilitative Therapy and Chiropractic Care Services:

a) Occupational therapy is provided only for purposes of training members to perform the activities of daily living

b) Speech therapy is not covered when (a) used to improve speech skills that have not fully developed; (b) considered custodial or educational; (c) intended to maintain speech communication; or (d) not restorative in nature

6.39 **Transplant Services.** Charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures. This coverage is subject to the following conditions and limitations

6.39.01 Charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures. This coverage is subject to the following conditions and limitations:

a) Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel, liver or multiple viscera.

b) Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

6.40 **Reconstructive Surgery.** Charges made for reconstructive surgery or therapy to repair or to correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or Conditions related to TMJ disorder) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same Condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician

## VII. EXCLUSIONS, EXPENSES NOT COVERED & GENERAL LIMITATIONS

**Please note:** No Claim will be paid on expenses which are not approved by Medicare except as stated in your Benefit Summary.

**Additional coverage limitations determined by Plan or provider type are shown in the Summary of Benefits. Payment for the following items and services are specifically excluded from this Plan.**

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

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

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

7.04 Charges made by a Hospital owned or operated by or which provides care for armed forces medical care for both sickness and injury, including services received at military or government facilities and services received to treat an injury arising out of your service in the Armed Forces, Reserves or National Guard.

7.05 Services to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with your participation in, or commission of, any act punishable by law as a misdemeanor or felony whether or not you are charged or convicted; or which constitutes riot or rebellion; or our engagement in an illegal occupation.

7.05.01 Coverage will be available if the Participant demonstrates that an injury resulted from an act of domestic violence or from a medical Condition, whether or not the condition has been diagnosed before the occurrence of the injury.

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

7.07 For **expenses incurred outside the United States** (except as outlined under Foreign Travel Medical Emergency/Accident Services) unless you or your Dependent are a resident of one or the other, and the charges are incurred while traveling on business or for pleasure;

7.08 For or in connection with **experimental, investigational or unproven services**: Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

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

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

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

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

7.09 **Cosmetic surgery and therapies.** Cosmetic services, including any surgery or non-surgical procedures which are undertaken primarily to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance, except for reconstructive surgery to correct and repair a functional disorder as a result of a disease, injury, or congenital defect, initial implanted prostheses and reconstructive surgery incident to a mastectomy for cancer of the breast.

7.10 **Cosmetic surgery** unless: (a) a person receives an Injury, which results in bodily damage requiring the surgery; (b) it qualifies as reconstructive surgery performed on a person following surgery, and both the surgery and the reconstructive surgery are essential and medically necessary; or (c) it is performed on any one of your Dependents who is less than 16 years old and who has reached skeletal maturity.

7.11 Regardless of clinical indication for rhinoplasty; blepharoplasty; acupressure; dance therapy; movement therapy; applied kinesiology; rolfing; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic Conditions.

7.12 For or in connection with **treatment of the teeth or periodontium** unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery.

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

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

7.15 **Infertility services** including surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.

7.16 Reversal of male and female voluntary sterilization procedures.

7.17 **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.

7.18 For **treatment of erectile dysfunction**. However, penile implants are covered when an established medical Condition is the cause of erectile dysfunction.

7.19 Medical and Hospital **care and costs for the infant child of a Dependent**, unless this infant child is otherwise eligible under this Plan.

7.20 **Nonmedical counseling or ancillary services**, including but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.

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

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

7.23 **Private Hospital rooms** (unless no semi-private room is available) and/or private duty nursing except as provided under the Home Health Services provision.

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

7.25 **Artificial aids** including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.

7.26 **Hearing aids**, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.

7.27 **Aids or devices that assist with nonverbal communications**, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.

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

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

7.30 **All non-injectable and injectable prescription drugs that do not require Physician supervision** and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this Plan.

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

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

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

7.34 **Dental implants** for any condition.

7.35 **Blood administration for the purpose of general improvement in physical Condition**.

7.36 Cost of **biologicals that are immunizations or medications for the purpose of travel**, or to **protect against occupational hazards and risks**.

7.37 **Cosmetics, dietary supplements and health and beauty aids**.

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

7.39 **Medical treatment** for a person age 65 or older, who is covered under this Plan as a retiree, or their Dependent, when payment is denied by the Medicare Plan because treatment was received **from a nonparticipating provider**.

7.40 **Medical treatment when payment is denied by a Primary Plan** because treatment was received from a **nonparticipating provider**.

7.41 For or in connection with an **Injury or Sickness** arising out of, or in the course of, any **employment for wage or profit**.

7.42 **Telephone, e-mail, Internet consultations and telemedicine** unless covered by Medicare.

7.43 **Massage therapy**.

7.44 For charges which would not have been made if the person had **no coverage**.

7.45 To the extent that they are **more than Maximum Reimbursable Charges**.

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

7.47 Charges made by any covered provider who is a member of your family or your Dependent's family.

7.48 To the extent of the exclusions imposed by any certification requirement shown in this Plan.

7.49 For or in connection with an **elective abortion** unless:

7.49.01 The Physician certifies in writing that the pregnancy would endanger the life of the mother; or

7.49.02 The expenses are incurred to treat medical complications due to the abortion.

## VIII. PRESCRIPTION DRUG BENEFIT EXCLUSIONS

**Subject to the following Exclusions, Prescription Drugs purchased at a Pharmacy are considered Covered Prescription Drugs under this benefit. No payment will be made for the following expenses:**

8.01 Food and Drug Administration (FDA) approved prescription drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital

Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer reviewed national professional medical journal;

8.02 Prescription drugs or medications used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido (excepting Viagra, limited to 8 pills per month when Medically Necessary);

8.03 Medications used to enhance athletic performance;

8.04 Medications which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;

8.05 Prescriptions more than one year from the original date of issue

## IX. COORDINATION OF BENEFITS

**This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all Claims with each Plan.**

**Definitions.** For the purposes of this Section, the following terms have the meanings set forth below:

9.01 **Plan** means any of the following, which provides medical or dental benefits or services: (a) group, blanket or franchise coverage; (b) service plan contracts, group or individual practice or other prepayment plans; or (c) coverage under any: labor-management trusteed plans; union welfare plans; employer organization plans; or employee benefit organization plans. Plan does not include coverage under individual policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

9.02 **Primary Plan** refers to the Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

9.03 **Secondary Plan** refers to a Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

9.04 **Allowable Expense** refers to the Maximum Allowable Payment or expense, including Deductibles, Coinsurance or Copayments, which are covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

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

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

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

d. If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on

the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

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

9.05 **Claim Determination Period** refers to one calendar year, but does not include any part of a year during which you are not covered under this Plan, or any date before this section, or any similar provision, takes effect.

9.06 **Reasonable Cash Value** is an amount which a duly licensed provider of health care services usually charges patients, and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

9.07 **Order of Benefit Determination Rules.** A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

9.07.01 The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;

9.07.02 If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

9.07.03 If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

b) Then, the Plan of the parent with custody of the child;

c) Then, the Plan of the spouse of the parent with custody of the child;

d) Then, the Plan of the parent not having custody of the child, and

e) Finally, the Plan of the spouse of the parent not having custody of the child.

9.07.04 The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

9.07.05 The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

9.07.06 If one of the Plans that cover you is issued out of the state whose laws govern this Plan, and determines the order of benefits based upon the gender of a parent, and as a result,

the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

9.07.07 If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

9.07.08 When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

9.08 **Effect on the Benefits of This Plan**

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

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

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

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

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

c) Whether there are any unpaid Allowable Expenses during the Claims Determination Period.

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

9.09 **Recovery of Excess Benefits**

9.09.01 If AvMed pays charges for benefits that should have been paid by the Primary Plan, or if AvMed pays charges in excess of those for which we are obligated to provide under the Plan, AvMed will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

9.09.02 AvMed will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any coverage company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

9.10 **Right to Receive and Release Information**

9.10.01 AvMed, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted Claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the Claim will be processed for payment. If no response is received

within 90 days of the request, the Claim will be denied. If the requested information is subsequently received, the Claim will be processed.

9.11 **Medicare Eligible**

9.11.01 AvMed will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

a) A former Employee who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan;

b) A former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan;

c) A retired Employee, or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

9.11.02 AvMed will assume the amount payable under:

a) Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.

b) Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.

c) Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

9.11.03 A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

9.11.04 This reduction will not apply to any former Employee and his Dependent unless he is listed under (a) through (c) above.

## X. SUBROGATION & RIGHT OF RECOVERY

10.01 If the Plan provides health care benefits under this SPD, to a Member, 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 Member, 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 Member, 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 insurance policy; any worker's compensation or disability award or settlement; medical payments insurance under any automobile policy, premises or homeowners medical payments insurance or premises or homeowners insurance; any other payments from a source intended to compensate a Member 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.

10.02 **Member 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 Member'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 Member's consent.

10.03 **Member 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 Member and/or the Member's representative has recovered any amounts from the third party or any party making payments on the third party's behalf. By providing any benefit under this SPD, the Plan is granted an assignment of the proceeds of any settlement, judgment or other payment received by the Member, to the extent of the full cost of all benefits provided by 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.

10.04 **Assent for Member Notification.** Member and the Member's representatives further agree to:

10.04.01 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 Member that may be the legal responsibility of a third party; and

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

10.04.03 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

10.04.04 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

10.04.05 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.

10.05 **Recovery of Full Cost.** 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 Member, 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 Member or the Member's representative fails to cooperate with the Plan, the Member 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.

10.06 **Payment of Benefits to Whom Payable**

10.06.01 All Medical Benefits are payable to you. However, at the option of AvMed, all or any part of them may be paid directly to the person or institution on whose charge Claim is based.

10.06.02 Medical Benefits are not assignable unless agreed to by AvMed. AvMed may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are

payable is a minor or, in the opinion of AvMed, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, AvMed may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

10.06.03 If you die while any of these benefits remain unpaid, AvMed may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

10.06.04 Payment as described above will release AvMed from all liability to the extent of any payment made.

10.07 **Time of Payment.** Benefits will be paid by AvMed when it receives due proof of loss.

10.08 **Recovery of Overpayment.** When an overpayment has been made by AvMed, AvMed will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future Claim payment.

## XI. TERMINATION OF COVERAGE

11.01 **Retirees.** Your coverage will cease on the earliest date below:

11.01.01 The date you cease to be in a Class of Eligible Retirees or cease to qualify for the coverage.

11.01.02 The last day for which you have made any required contribution for the coverage.

11.01.03 The date the Plan is canceled.

11.02 **Dependents.** Your coverage for all of your Dependents including Domestic Partner will cease on the earliest date below:

11.02.01 The date your coverage ceases.

11.02.02 The date you cease to be eligible for Dependent or Domestic Partner coverage.

11.02.03 The last day for which you have made any required contribution for the coverage.

11.02.04 The date Dependent or Domestic Partner coverage is canceled.

11.02.05 The coverage for any one of your Dependents including Domestic Partner will cease on the date that Dependent or Domestic Partner no longer qualifies as a Dependent.

## XII. FEDERAL REQUIREMENTS

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this document, the provision which provides the better benefit will apply.

12.01 **Eligibility for Coverage Under a QMCSO**

12.01.01 If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a late entrant for Dependent coverage.

12.01.02 You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

12.02 **Qualified Medical Child Support Order Defined**

12.02.01 A Qualified Medical Child Support Order is a judgment, decree or order (including

approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

a. The order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
b. The order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
c. The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
d. The order states the period to which it applies; and
e. If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

12.02.02 The QMCSO may not require the health coverage Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan, except that an order may require a plan to comply with State laws regarding health care coverage.

12.03 **Payment of Benefits**

12.03.01 Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

12.04 **Michelle's Law**

12.04.01 In the event the enrolled Dependent child, who is a Full-Time or Part-time Student, suffers from a serious illness or injury requiring a leave of absence from school which would otherwise cause the Dependent child to lose eligibility under the Plan, coverage will be extended for one year from the first day of the leave of absence or the date on which coverage under the Plan would otherwise terminate, whichever occurs first. AvMed will require written certification from a treating physician stating that the Dependent is suffering from a serious illness or injury and that the leave of absence is Medically Necessary.

## XIII. SPECIAL ENROLLMENT RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

13.01 If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

13.01.01 Acquiring a new Dependent. If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan:

Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren), Employee and Domestic Partner or Employee, Domestic Partner and the child of a Domestic Partner. Enrollment of Dependent children or children of a Domestic Partner is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.

13.01.02 Loss of eligibility for other coverage (excluding continuation coverage). If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) including Domestic Partner may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:

i. Divorce, legal separation or termination of Domestic Partnership;
ii. Cessation of Dependent status (such as reaching the limiting age);
iii. Death of the Employee;
iv. Termination of employment;
v. Reduction in work hours to below the minimum required for eligibility;
vi. You or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
vii. You or your Dependent(s) incur a Claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
viii. The other plan no longer offers any benefits to a class of similarly situated individuals.

13.02 **CHIPRA Employees and their Dependents** who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within 60 days following:

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

13.02.02 Determination of eligibility for premium assistance under Medicaid or CHIP.

13.02.03 The employee or Dependent must complete and submit an Enrollment or Status Change form within 60 days of the date of the loss of Medicaid or CHIP coverage, and within 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.

13.03 **Termination of former employer contributions (excluding continuation coverage**

13.03.01 If a current or former employer ceases all significant contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).

13.04 **Exhaustion of COBRA or other continuation coverage**

13.04.01 Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of

coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: (a) due to failure of the employer or other responsible entity to remit premiums on a timely basis; (b) when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or (c) when the individual incurs a Claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

13.04.02 Special enrollment must be requested within 45 days after the occurrence of the special enrollment event or 60 days following birth or the earlier of adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

13.04.03 Individuals who enroll in the Plan due to a special enrollment event will not be denied enrollment. You will not be enrolled in this Plan if you do not enroll within 45 days of the date you become eligible, unless you are eligible for special enrollment.

13.05 **Eligibility for Coverage for Adopted Children**

13.05.01 Any child under the age of 26 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent coverage from the earlier of 1) date of adoption or 2) placement in the home. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

13.05.02 If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

13.05.03 The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of coverage will also apply to an adopted child or a child placed with you for adoption.

13.06 **Federal Tax Implications for Dependent Coverage**

Premium payments for Dependent health coverage are usually exempt from federal income tax. Generally, if you can claim an individual as a Dependent for purposes of federal income tax, then the premium for that Dependent's health coverage will not be taxable to you as income. However, in the rare instance that you cover an individual under your health coverage who does not meet the federal definition of a Dependent, the premium may be taxable to you as income. If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

13.07 **Coverage for Maternity Hospital Stay**

13.07.01 Issuers offering health coverage generally may not, under a federal law known as the "Newborns' and Mothers' Health Protection Act": restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the plan or coverage issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with

the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

13.07.02 Please review this Plan for further details on the specific coverage available to you and your Dependents.

13.08 **Women's Health and Cancer Rights Act (WHCRA)**

13.08.01 Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call AvMed's Member Engagement Center at the toll free at 1-800-682-8633 for more information.

13.09 **Group Plan Coverage Instead of Medicaid**

13.09.01 If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

13.10 **Obtaining a Certificate of Creditable Coverage Under This Plan**

13.10.01 Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan, and for 24 months following termination of coverage. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call the toll-free customer service number on the back of your ID card.

## XIV. WHEN YOU HAVE A COMPLAINT OR AN APPEAL

14.01 Members 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.

14.02 **Grievances Relating to Plan Services**

14.02.01 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 Covered Person's complaint cannot be resolved in this manner (i.e. over the telephone), the Covered Person 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 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

14.03 **Urgent Care Claims**

14.03.01 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.

14.03.02 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 3 days after the oral notification.

14.03.03 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.

a) You may submit an appeal to:

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

14.03.04 Second Level Appeal. If the Claimant is not satisfied with the first level appeal decision, he may request a second review within 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 Health Plans 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 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.

14.03.05 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 30 calendar days unless the request meets expedited criteria, in which case it will be resolved within 3 days.

14.03.06 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.

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

14.03.08 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

14.03.09 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 30 working days and written notification will be provided to the Covered Person. However, this process in no way extends the 60 day period to file a written appeal with AvMed.

14.04 **Pre-Service Claims**

14.04.01 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 15 days after AvMed receives the Pre-Service Claim. AvMed may extend this period one time for up to 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 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 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 45-day period, the Claim shall be denied.

14.04.02 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 15 days after the Plan receives the Claimant's request for review of the Adverse Benefit Determination.

a) You may submit an appeal to:

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

14.04.03 Second Level Appeal. If the Claimant is not satisfied with the first level appeal decision, he may request a second review within 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 Health Plans 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 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.

14.04.04 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 30 calendar days unless the request meets expedited criteria, in which case it will be resolved within 3 days.

14.04.05 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.

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

14.04.07 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

14.04.08 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 30 working days and written notification will be provided to the Covered Person. However, this process in no way extends the 60 day period in which you are required to file a written appeal with AvMed.

14.05 **Post-Service Claims**

14.05.01 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 30 days after AvMed receives the Post-Service Claim. AvMed may extend this period

one time for up to 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 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 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 45-day period, the Claim shall be denied.

14.05.02 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 30 days after the Plan receives the Claimant's request for review of the Adverse Benefit Determination.

a) You may submit an appeal to:

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

14.05.03 Second Level Appeal. If the Claimant is not satisfied with the first level appeal decision, he may request a second review within 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 Health Plans 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 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.

14.05.04 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 30 calendar days unless the request meets expedited criteria, in which case it will be resolved within 3 days.

14.05.05 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.

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

14.05.07 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

14.05.08 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 30 working days and written notification will be provided to the Covered Person. However, this process in no way extends the 60 day period in which you are required to file a written appeal with AvMed.

14.06 **Concurrent Care Claims**

14.06.01 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.

14.06.02 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.

14.07 **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:

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

14.07.02 Reference to the specific Plan provisions on which the determination is based.

14.07.03 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.

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

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

14.07.06 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.

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

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

14.08.01 Claimant may submit written comments, documents, records, and other information relating to the claim.

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

14.08.03 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 sufficient in advance of the due date of the response to the adverse benefit determination.

14.08.04 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.

14.08.05 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.

14.08.06 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.

14.08.07 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.

14.08.08 The appeal shall provide that the Health Professional engaged for proposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

14.08.09 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.

14.09 **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.

14.09.01 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.

14.09.02 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.

14.10 **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

## XV. COBRA CONTINUATION RIGHTS UNDER FEDERAL LAW

15.01 **Certificates of Creditable Coverage.** Upon termination of a Member's coverage under the Plan, including termination of any COBRA continuation coverage, the Member has the right to receive within a reasonable period of time, a certificate of creditable coverage, which shows the continuous amount of coverage the Member had under the Plan. The Member may also request a certificate during the time he or she is covered under the Plan and any time within 24 months after the Member ceases to be covered under the Plan.

15.02 **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.

15.02.01 Your enrolled dependents will become eligible for COBRA continuation coverage for up to 36 months 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; or

c) Your dependent child no longer qualifies as a dependent under the Plan.

15.02.02 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.

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

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

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

15.04 **Cost.** If you elect to continue coverage, you must pay the entire cost of coverage, plus a 2% administrative fee for the duration of COBRA continuation coverage.

15.04.01 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 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.)

15.05 **Duration.** COBRA Continuation Coverage can be extended for up to:

15.05.01 36 months for dependents, if your dependents lose eligibility for medical coverage due to your death, divorce, legal separation or termination of Domestic Partnership, your entitlement to Medicare after your termination or reduction in hours, or your dependent child ceasing to qualify as a dependent under the Plan.

15.06 **Termination of COBRA Continuation**

15.06.01 COBRA continuation coverage will be terminated upon the occurrence of any of the following:

a) The end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
b) Failure to pay the required premium within 30 calendar days after the due date;
c) Cancellation of the Employer's Plan with AvMed;
d) After electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);

15.06.02 After electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a Condition for which the new plan limits or excludes coverage under a preexisting Condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing Condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or

15.06.02 Any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

15.07 **COBRA Continuation for Retirees Following Employer's Bankruptcy**

15.07.01 If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your Covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse, Domestic Partner, children of a Domestic Partner and Covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

**The Schedule is a brief outline of your maximum benefits which may be payable under your Plan. For a full description of each benefits, refer to the appropriate section listed in the Table of Contents.**