HMO INDIVIDUAL
CERTIFICATE OF COVERAGE

With Integrated Prescription Drug Coverage

THIS IS A LEGAL CONTRACT BETWEEN YOU AND US.

IMPORTANT NOTICE

Issuance of this Certificate of Coverage is based on Your answers to the questions on Your application or HealthCare.gov account. If, for any reason, Your answers are incorrect, contact Us, or the Health Insurance Marketplace ("Marketplace") for HealthCare.gov submissions, within ten (10) calendar days. Omissions or misstatements on the application could cause Your Claims to be denied or Coverage to be rescinded.

This Individual Certificate of Coverage (hereinafter called the "Certificate", "Individual Policy", or "Health Benefit Plan") issued by Health First Commercial Plans, Inc. d/b/a Health First Health Plans (hereinafter called the "Health Plan") to a Policyholder (hereinafter called the "Insured"), sets forth the basis on which an eligible person is provided with Coverage for Health Care Services and benefits. Upon acceptance for Coverage, an Insured is entitled to Covered Services provided by the Health Plan commencing with each Insured's Coverage Effective Date. Coverage is not provided for any Services rendered prior to the Effective Date of Coverage or after the termination date of this Certificate. During the term of this Certificate, We agree to provide the health insurance Coverage and benefits specifically provided in this Certificate to the Insured and their Covered Dependents (hereinafter called "Covered Person(s)"), subject to all applicable terms, conditions, limitations, and exclusions.

Ten Day Right to Examine and Return Policy

Please read this Individual Policy carefully. If, for any reason, You are not satisfied, You may return this Individual Policy to Us, or the Marketplace (if applicable), within ten (10) calendar days after receiving it. If returned, the Individual Policy will be void from its beginning, and any Premium paid will be refunded.

Guaranteed Renewable for Life – Premiums Subject to Change

This Certificate is renewable as long as You live, unless it is terminated as provided in this Certificate, so long as You continue to pay Premiums when due. Premiums are based on Your attained age. The Premium may change if a new table of rates is applicable to the Certificate. The change in the table of rates will apply to all Covered Persons in the same class on the date of the change. Class is defined as location (state and Zone Improvement Plan ("ZIP") code of residence), age, family size, tobacco use, and plan category. Any Premium change will be filed and approved by the Florida Office of Insurance Regulation ("OIR") and the Centers for Medicare & Medicaid Services ("CMS"), if applicable, prior to any Premium adjustment. This Certificate can be rescinded or canceled if You have made a fraudulent or Material Misrepresentation or omission on Your application. This Certificate can be canceled if We terminate the Individual Policy for everyone Covered by it. You will be notified at least forty-five (45) calendar days in advance before any change in the table of rates or at least ninety (90) calendar days before termination of the Individual Policy.

The Health Plan does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

THIS PLAN INCLUDES A DEDUCTIBLE PROVISION

Matt Gerrell
CEO
Health First Commercial Plans, Inc.

INDIVIDUAL PLAN INFORMATION PAGE

Insured:

Plan:

Certificate Effective Date:

Term of Coverage:

Monthly Premium Due:

Premium Due Dates:

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I. INTRODUCTION TO YOUR CERTIFICATE OF COVERAGE

This is Your Certificate. You should read it carefully before You need Health Care Services. It contains valuable information about:

- Your health plan benefits;
- What Health Care Services are Covered;
- What Health Care Services are excluded or not Covered;
- Our Coverage and any payment rules;
- How and when to file a Claim;
- How much, and under what circumstances, the Health Plan will pay;
- What You will have to pay as Your share; and
- Other important information, including:
  - When benefits may change;
  - How and when Coverage stops;
  - How We will coordinate benefits with other policies or plans;
  - Our subrogation rights; and
  - Our right of reimbursement.

Please refer to Your Schedule of Benefits included in this Certificate to determine how much You have to pay for particular Health Care Services.

When reading Your Certificate, please remember:

- You should read this Certificate in its entirety in order to determine if a particular Health Care Service is Covered;
- The headings of sections contained in this Certificate are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions;
- References to "You", "Your", or "Yourself" throughout refer to You as the Insured, and to Your Covered Dependent(s). This is true unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references which refer solely to You as the Insured, or solely to Your Covered Dependent(s) will be noted as such;
- References to "We", "Us", and "Our" throughout refer to Health First Commercial Plans, Inc. d/b/a Health First Health Plans. We may also refer to Ourselves as the "Health Plan"; and
- If a word or phrase starts with a capital letter, it is either the first word in a sentence, a title, a proper name, or a defined term. If the word or phrase has a special meaning, it will either be defined in the **Definitions** section or defined within the particular section where it is used.

ENTIRE CONTRACT; CHANGES

This Certificate, with the application and attached documents, is the entire contract between the Insured and the Health Plan. No change in this Certificate will be effective until approved by an officer of the Health Plan. This approval must be noted on or attached to this Certificate. No agent may change this Certificate or waive any of its provisions.

II. ADMINISTRATIVE PROVISIONS

A. ELIGIBILITY

ELIGIBILITY REQUIREMENTS FOR INSUREDS

Any individual who meets and continues to meet Our eligibility requirements described in the Certificate, shall be entitled to apply for Coverage with Us under this Certificate. These eligibility requirements are binding upon You and/or Your eligible family members. We may require applicable documentation that an individual meets and continues to meet the eligibility requirements. Examples of documentation are copies of a court order naming the Insured as the legal guardian, proof of residency, or appropriate Adoption documentation described in the "Dependent Enrollment" subsection.

In order to enroll in this Health Benefit Plan, all Applicants must:

- Be a U.S. citizen or national (or be lawfully present);
- Not already be enrolled in a Medicare plan at the time of the application;
- Continually and permanently live within the Health Plan's Service Area;
- Submit a completed and signed enrollment application, including all requested information, or apply through the Marketplace;
- Pay the required Premiums; and
- Not be currently incarcerated.

In addition to the eligibility requirements listed above, Applicants enrolling in a Catastrophic Health Plan must also meet one (1) of the following requirements:

- Must be under the age of thirty (30); or
- Must qualify for and have received a hardship exemption from the Marketplace.

An individual must visit the Marketplace directly to determine eligibility for, and enroll in, a Catastrophic Health Plan.

Coverage is not effective until the Applicant is notified in writing by the Health Plan, or the Marketplace, of such date Coverage is to commence.

CHILD-ONLY POLICIES

An Individual who meets the eligibility requirements outlined above, and who has not attained the age of twenty-one (21) at the beginning of the Benefit Year, is eligible for a child-only policy. An Advance Premium Tax Credit ("APTC") may be available to the parent/legal guardian who purchases Coverage on behalf of a qualifying dependent child. In determining the parent's/legal guardian's premium tax credit eligibility, a qualifying dependent child is defined as:

- A child of the taxpayer or descendent of such child. The brother, sister, stepbrother, or stepsister of the taxpayer or a descendent of any such relative;
- Has the same principal place of residence as the taxpayer for more than half of the year;
- Has not reached the age of nineteen (19) by the end of the Calendar Year, is a student who has not reached the age of twenty-four (24) by the end of the Calendar Year, or is permanently disabled;
- Has not provided over one-half of his or her own support for the Calendar Year; and
- Has not filed a joint return with his or her Spouse.

As specified by the Affordable Care Act ("ACA"), the parent/legal guardian who claims the child on their tax return must provide that child with Coverage.

ELIGIBILITY REQUIREMENTS FOR DEPENDENTS

Any individual who meets the following criteria for Eligible Dependents may apply for Coverage under this Certificate:

- Was named on the initial application for, or properly enrolled under, this Certificate;
- Must not already be enrolled in a Medicare plan at the time of the application; and
- Must pay the applicable Premium.

An Eligible Dependent is considered one (1) of the following:

- The Insured's Spouse under a legally valid, existing marriage;
- The Insured's Domestic Partner. A Domestic Partner means an adult of the same or opposite sex with whom the Insured is in a Domestic Partnership;
- The Covered Insured's, Covered Spouse's, or Covered Domestic Partner's legal dependent who has not turned age twenty-six (26) at the end of the Calendar Year preceding the year of Coverage for this Individual Policy, and includes a:
  - Natural born child;
  - Newborn child;
  - Adopted child;
  - Foster child;
  - Step child; or
  - Child for whom the Covered Insured, Covered Spouse, or Covered Domestic Partner has been court appointed as legal guardian or legal custodian; or
- The Newborn child of a Covered Dependent child. Coverage for such Newborn child will automatically terminate eighteen (18) months after the birth of the Newborn child. The Health Plan must be notified of a Newborn add-on within sixty (60) days of birth. If notice is not given within sixty (60) days of the birth of a child, then the Health Plan will deny Coverage for that Newborn child.

A Dependent child may continue Coverage from the end of the Calendar Year in which they turn age twenty-six (26) until the end of the Calendar Year in which they reach age thirty (30), if the child meets the following requirements:

- Has no dependents of their own;
- Is Unmarried;
- Is a Florida resident or a full or part-time student; and
- Is not provided Coverage under any other group, blanket, or franchise health insurance policy, individual health benefit plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

If the child continues Coverage beyond the end of the Calendar Year in which the child reaches age twenty-six (26) and is subsequently terminated, the child is not eligible to be Covered under the parent's plan unless the child was continuously Covered by other Creditable Coverage without a gap in Coverage of more than sixty-three (63) days.

If the Health Plan accepts a Premium payment after the date the child was no longer eligible, Coverage will continue in force, subject to any right of cancellation, until the end of the period for which the Premium has been accepted. In the event the age of the child has been misstated and if, according to the correct age of the child, the Coverage provided by the Individual Policy would not have become effective, or would have ceased prior to the acceptance of such Premium or Premiums, then the liability of the Health Plan shall, upon discovery of the error, be limited to the refund of all Premiums paid for the period not Covered by the Individual Policy.

Note**:** It is the sole responsibility of the Insured to establish that a child meets the applicable eligibility

requirements. Eligibility will terminate at the end of the Calendar Year in which the child no longer meets the dependent eligibility criteria required to be an Eligible Dependent. The Health Plan reserves the right to periodically audit dependent eligibility status and to request proof of a child's dependency status at any time.

EXTENSION OF ELIGIBILITY FOR DEPENDENT CHILDREN WITH DISABILITIES
CHILDREN WITH DISABILITIES

A Covered Dependent child with an intellectual or physical disability is eligible to continue Coverage beyond the limiting age of thirty (30), if the child is, and continues to be both:

- Incapable of self-sustaining employment by reason of intellectual disability or physical disability, and
- Chiefly dependent upon the Covered Insured, the Insured's Covered Spouse, or the Insured's Covered Domestic Partner for support and maintenance.

The term support, as used above, includes an Eligible Dependent that is claimed as a dependent on the Insured's Federal Tax Return.

If a Claim is denied for the stated reason that the child has reached the limiting age for dependent Coverage, the Insured has the burden of establishing that the child is and continues to be disabled as defined above.

The Coverage of the disabled child may be continued, but not beyond the termination date of such incapacity or such dependence. In no event shall this provision limit the application of any other provision of the Health Plan terminating such child's Coverage for any other reason other than the attainment of the applicable limiting age.

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

OTHER REQUIREMENTS/RULES REGARDING ELIGIBILITY

- No individual whose Coverage with the Health Plan has been terminated for cause or any other reason listed in the **Termination Provisions** section shall be eligible to re-enroll with the Health Plan.
- The Health Plan agrees to provide Coverage without discrimination on the basis of race, color, sex, religion, national origin, disability, age, gender identity, sexual orientation, or any other basis prohibited by law.
- The Insured must notify Us in writing as soon as possible when a Covered Dependent is no longer eligible for Coverage. In addition, any Insured who enrolled through the Marketplace is responsible for notifying the Marketplace of all change in circumstance events that would result in eligibility changes (e.g., marriage, divorce, or birth of a Newborn).
    - If a Covered Dependent fails to continue to meet each of the eligibility requirements under this Certificate, and such proper notification is not provided to Us timely (and to the Marketplace for Insureds enrolled in a Marketplace plan), We shall have the right to retroactively terminate Coverage of such Covered Dependent to the date any such eligibility requirement was not met. We also have the right to recover an amount equal to the Allowed Amount for Health Care Services provided following such date, upon notification from the Marketplace, less any Premiums and other applicable charges received by Us for such dependent for Coverage after such date.
    - We reserve the right to request that the Insured provide proof, which is acceptable to Us, of a Covered Dependent's continued eligibility for Coverage.

- For disputes relating to dependents removed from Coverage due to failure to provide documentation substantiating their eligibility, You should include the documentation that will prove the dependent is eligible along with Your letter. If approved, Coverage will be reinstated retroactively sixty (60) days from the date You submit Your Appeal or the date Your dependent was removed from Coverage.

GENERAL RULES FOR ENROLLMENT

- All factual representations made by You to Us in writing in connection with the issuance of this Certificate and enrollment hereunder must be accurate and complete. Any false, fraudulent, or misleading information provided during the enrollment process, or at any other time, may result, in addition to any other legal right(s) We may have, in disqualification for, termination of, or rescission of Coverage.
- We will not provide Coverage and benefits to any individual who would not have been entitled to enrollment with Us had accurate and complete information been provided to Us on a timely basis. In such cases, We may require You, or an individual legally responsible for You, to reimburse Us for any payment We made on Your behalf.
- A qualified individual may enroll in this Individual Policy, or through the Marketplace at HealthCare.gov. The Marketplace follows enrollment rules specified by the Federal Government and the State of Florida. These enrollment rules may or may not apply if You enroll in this Individual Policy directly with Us. If You enroll in this Individual Policy through the Marketplace, You may be eligible for tax credits to help pay for Your cost of Coverage. The following sections discuss the rules and benefits of enrollment through the Marketplace.
- Fraud or an intentional misrepresentation of material fact, omissions, concealment of facts, and incorrect statements made by the Applicant or Covered Dependents, which are discovered by the Health Plan or the Marketplace, may prevent payment of benefits under this Certificate, may void this Certificate, and may cause Claims to be denied for the individual making, or the subject of, the misrepresentation, omission, concealment of facts, or incorrect statement.
- If, in applying for this Certificate or in enrolling Yourself or Your dependents, You make a fraudulent statement or misrepresentation pertaining to information such as Your geographical area, gender, age, or the gender and/or age of Your dependents, Our sole liability shall be the return of any unearned Premium, less benefit payments. However, at Our discretion, We may elect to cancel the Certificate with forty-five (45) calendar days prior written notice or continue this Certificate provided that the Insured makes payment to Us for the full amount of the Premium which would have been in effect had You stated the true facts.

APPLYING FOR COVERAGE

To apply for Coverage under this Certificate through the Marketplace, You must:

- Create a Marketplace account on HealthCare.gov;
- Fill out and submit an online application or download and complete a paper application. You can also apply by phone or in-person with an assister;
- Review and save the notice You receive that tells You what Coverage You are eligible for. You will receive this notice in the mail or in an email;
- If You are eligible, shop for and enroll in the Health Plan's Marketplace plan; and
- Send Your first Premium payment to the Health Plan within the required time frame.

To apply for Coverage under this Certificate with the Health Plan, outside of the Marketplace, You must:

- Complete and submit an application to Us;
- Provide information needed to determine eligibility, as requested;
- Pay the required Premium within the required time frame; and
- If You would also like to enroll Your dependents, complete and submit the required enrollment forms to add Eligible Dependents.

By submitting an application, You represent that You have permission from all of the people whose information is on the application to both submit their information to Us or the Marketplace and receive any communications about their eligibility and enrollment.

EFFECTIVE DATE OF COVERAGE

Coverage shall become effective at midnight, Eastern Time, on the Covered Person's Effective Date (shown on the Individual Plan Information Page of this Certificate).

ANNUAL OPEN ENROLLMENT PERIOD ("OEP")

The Open Enrollment Period ("OEP") is the period of time each year, determined by the Marketplace or the Health Plan, when You can enroll in an Individual health insurance policy or change Your Coverage. Any changes made to Your Coverage during the OEP can be effective as early as January 1st. If You do not enroll or change Coverage during the OEP, You must wait until the next OEP to elect or change Coverage, unless You or Your Eligible Dependents qualify for a Special Enrollment Period ("SEP").

SPECIAL ENROLLMENT PERIOD ("SEP")

To enroll in Coverage under this Certificate or change Your Coverage outside the annual OEP, You must qualify for an SEP. An SEP is a period of time, up to sixty (60) days before or sixty (60) days following a qualifying life event, during which You may apply for Coverage. The Effective Date of Your new Coverage will depend on what type of qualifying life event occurred.

If You qualify for an SEP and do not make the necessary changes to Your health insurance during the SEP, You will have to wait until the next OEP to make any changes. Qualifying life events are established by state and federal law and include:

- Gaining a dependent (e.g., marriage, birth of a Newborn child, Adoption, or placement for Adoption or foster care);
- Loss of minimum essential Coverage (e.g., job loss, divorce, aging off a parent's plan);
- Moving Your residence, gaining U.S. citizenship, or leaving incarceration; and
- Having a change in income or household status that affects eligibility for premium tax credits or Cost-Sharing reductions.

For more detailed information on what events qualify for an SEP, the length of the SEP, and to see if You qualify for an SEP, go to HealthCare.gov or contact Us.

DEPENDENT ENROLLMENT

An individual may be added upon becoming an Eligible Dependent of an Insured during an SEP.

Newborn Child – To enroll a Newborn child who is an Eligible Dependent, You must submit a request for Coverage using enrollment forms approved by Us. To add a Newborn through the Marketplace, contact the Marketplace or one of Our licensed sales agents and report the life change. We must be notified of all Newborn enrollments.

If We receive written notice for enrollment from You, or from the Marketplace, within thirty-one (31) calendar days of the birth of the Newborn, the Effective Date of Coverage will be the moment of birth, and no Premium will be charged for the Newborn child for the first thirty-one (31) calendar days of Coverage.

If We receive written notice within thirty-two (32) to sixty (60) calendar days after the date of birth, the Effective Date of Coverage will be the moment of birth, and the Premium will be charged from the date of birth. If notice of the birth is not given within sixty (60) days of birth, You will need to wait until the next annual OEP.

Newborn Child of a Covered Dependent Child – Coverage for a Newborn child of a Covered family member other than the Insured's Spouse or Domestic Partner will automatically terminate eighteen (18) months after the birth of the Newborn child. If a Newborn child is to be added to the Individual Policy, the Health Plan must be notified within sixty (60) days of birth. If written notice is not given within sixty (60) days of the birth of a child, then the Health Plan will deny Coverage for that Newborn child.

Adopted Newborn Child – To enroll an Adopted Newborn child, You must submit a request for Coverage using enrollment forms approved by Us. To add an Adopted Newborn child through the Marketplace, contact the Marketplace or one of Our licensed sales agents and report the life change. We must be notified of all Adopted Newborn child enrollments.

Adopted Newborn child Coverage shall take effect at the moment of birth provided the Health Plan is notified by the Covered Person to enroll the child within sixty (60) days of the Adopted Newborn child's moment of birth.

- If the Covered Person enrolls the Adopted Newborn child within thirty-one (31) days of the birth, no Premium will be charged for the first thirty-one (31) days of Coverage;
- If We receive written notice within thirty-two (32) to sixty (60) days after the date of birth, Premium will be charged from the date of birth; and
- If notice of the birth is not given within sixty (60) days of birth, You will need to wait until the next annual OEP.

For all children Covered as Adopted children, if the final decree of Adoption is not issued, Coverage shall not be continued for the proposed Adopted child under this Certificate. Proof of final Adoption must be submitted to Us. It is Your responsibility to notify Us or the Marketplace if the Adoption does not take place. Upon receipt of this notification, We will terminate the Coverage of the Adopted Newborn child on the first billing date following Our receipt of the written notice.

Adopted/Foster Children – To enroll an Adopted child (other than a Newborn) or Foster Child, prior to the child's eighteenth (18th) birthday, You must submit any enrollment forms We require to Us. To add an Adopted or Foster Child through the Marketplace, contact the Marketplace or one of Our licensed sales agents and report the life change. We must be notified of all Adopted or Foster Child enrollments.

Coverage shall be effective the date such Adopted or Foster Child is placed in the Insured's residence, pursuant to Florida law, provided the Health Plan is notified to enroll the child within sixty (60) days of the child's placement. If notice of the placement is not given within sixty (60) days of the child's placement in the Insured's residence, the Adopted or Foster Child will be ineligible to enroll for Coverage until the next annual OEP.

For all children Covered as Adopted children, if the final decree of Adoption is not issued, Coverage shall not be continued for the proposed Adopted child under this Certificate. Proof of final Adoption must be submitted to Us. It is Your responsibility to notify Us or the Marketplace if the Adoption does not take place. Upon receipt of this notification, We will terminate the Coverage of the child on the first billing date following Our receipt of the written notice.

If Your status as a foster parent is terminated, Coverage shall not be continued for any Foster Child. It is Your responsibility to notify Us that the Foster Child is no longer in Your care. Additionally, if You enrolled in a Marketplace plan, it is Your responsibility to notify the Marketplace

that the Foster Child is no longer in Your care. Upon receipt of this notification, We will terminate the Coverage of the child on the first billing date following Our receipt of the written notice.

Other Dependents – If other Eligible Dependents were not named on the application for this Certificate, You may apply for Coverage for the Eligible Dependents during an SEP. Newly Eligible Dependents can become Covered when You submit the required enrollment forms to Us or notify the Marketplace of a qualifying life event. If notice of the newly Eligible Dependent is not given during the SEP, the dependent will be ineligible to enroll for Coverage until the next annual OEP.

Marital Status – You may apply for Coverage for an Eligible Dependent Spouse due to marriage. To apply for Coverage outside the Marketplace, the Insured must:

- Complete and submit the enrollment forms approved by Us; and
- Pay the applicable Premium.

To apply for Coverage under this Certificate through the Marketplace, the Insured must:

- Contact the Marketplace or one of Our licensed sales agents and report the qualifying life event; and
- Send the additional Premium payment to the Health Plan, within the required time frame.

If received within thirty (30) days following the date of marriage, the Effective Date of Coverage shall be no later than the first day of the first month beginning after the date the completed request for enrollment is received by Us. If received after day thirty (30), but before day sixty (60) following the date of marriage, the Effective Date will be the first day of the following month. If notice is not given within sixty (60) days following the date of marriage, the Spouse will be ineligible to enroll for Coverage until the next annual OEP.

Court Order – You may apply for Coverage for an Eligible Dependent if a court has ordered Coverage to be provided by You for a minor child. To apply for Coverage, You must submit a request for Coverage using enrollment forms approved by Us. To add an Eligible Dependent child through the Marketplace, contact the Marketplace or one of Our licensed sales agents to report the life event. If accepted, the Effective Date of Coverage for the Eligible Dependent shall be determined by Us based on the court documentation, or in the case of Marketplace enrollment, by the Marketplace. You must pay the additional Premium for Coverage to be provided to the Eligible Dependent.

B. RENEWAL CONDITIONS

Coverage under this Certificate is for an initial Benefit Year and will automatically renew for successive Benefit Years, unless terminated as provided for in this Certificate. The Benefit Year for plans purchased inside or outside the Marketplace begins January 1st of each year and ends December 31st of the same year. The Benefit Year ends December 31st even if the Insured's Coverage started after January 1st. Any changes to benefits or rates for a health insurance plan are made at the beginning of the Calendar Year. This plan is guaranteed renewable. However, the Health Plan may refuse to renew this Certificate and all Coverage provided for under this Certificate for any of the following reasons:

- The Insured fails to timely pay Premium in accordance with the terms of the Certificate;
- The Health Plan ceases offering this Certificate to all Insureds;
- The Covered Person has performed a fraudulent act or practice or made an intentional misrepresentation of material fact under the terms of this Certificate;
- The Insured no longer permanently lives in the Health Plan's Service Area; or
- The Health Plan elects to discontinue all Individual health insurance Coverage in the Service Area.

With the exception of non-payment of Premium, if the Health Plan decides to non-renew this Certificate for any of the reasons set forth above, the Health Plan will provide the Insured with forty-five (45) calendar days advance written notice. If the Health Plan ceases offering this Certificate to all Insureds, the Health Plan will provide the Insured ninety (90) calendar days written notice prior to the renewal date and offer the option to purchase any other Individual coverage currently being marketed by the Health Plan in the Service Area. If the Health Plan discontinues offering all Individual Coverage in the Service Area, the Health Plan will give all Insureds one hundred and eighty (180) calendar days written notice prior to the Certificate renewal date.

C. TERMINATION PROVISIONS

VOLUNTARY TERMINATION OF COVERAGE

An Insured may voluntarily terminate Coverage at any time.

If You enrolled through the Marketplace, You must contact the Marketplace to terminate Your Coverage. The Effective Date of the termination will be processed and the Premiums will be pro-rated accordingly.

If You enrolled outside of the Marketplace, the Insured must contact the Health Plan to request disenrollment. Your Coverage will end on the last day of the month in which the termination is requested. A termination request cannot be applied retroactively.

While still Covered under the Health Plan, the Insured shall be responsible for any required Premium payment after the Health Plan receives notification of disenrollment. Any Insured who elects to terminate Coverage will not be able to enroll in a new plan until the next annual OEP, unless the Insured qualifies for an SEP. Non-payment of Premium does not constitute voluntary termination.

INVOLUNTARY TERMINATION OF COVERAGE

Unless otherwise prohibited by law, if, in the Health Plan's opinion, any of the following events occur, Coverage may be terminated:

- Disenrollment for Cause
    - If a Covered Person engages in fraudulent activity in the use of Services or Facilities, Providers, or knowingly permits such fraud by another, the Health Plan may terminate the rights of the Covered Person involved immediately upon written notification by the Health Plan to the Covered Person. If such activity does occur, the Health Plan reserves the rights to recoup any funds paid out under false pretenses or rescind the Certificate in its entirety.

  Coverage will terminate on the date specified by the Health Plan if any of the following events occur:

    - Fraud, intentional misrepresentation of material fact, or omission in applying for Coverage under this Certificate by You or on Your behalf;
    - Misuse of the ID card; or
    - A Covered Person's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative, to the extent that such Covered Person's continued Coverage seriously impairs the Health Plan's ability to provide Coverage and/or arrange for the delivery of Health Care Services to the Covered Person. Prior to disenrolling a Covered Person for any of the above reasons, the Health Plan will:
        - Make a reasonable effort to resolve the problem presented by the Covered Person, including the use or attempted use of the Health Plan's Grievance Procedure;

- To the extent possible, ascertain that the Covered Person's behavior is not related to the use of medical Services or mental illness; and
- Document the problems encountered, efforts made to resolve the problems, and any of the Covered Person's medical Conditions involved.

- Non-Payment of Premiums

  If the Health Plan fails to receive Premiums no later than the last day of the Grace Period, Coverage under this Individual Policy will terminate according to the time frames addressed in the **Grace Period** section. The Health Plan will mail notice of termination to the Certificate Holder forty-five (45) calendar days in advance of the premium due date. The termination effective date will be the initial premium due date. If Coverage is terminated for non-payment of Premium as set forth in this Certificate, the Health Plan will mail written notification that this Individual Policy has terminated within ten (10) business days after the date of termination. This notification will state the date of termination and the reason(s) for termination.

- A Covered Dependent of the Insured reaches the limiting age under the Individual Policy, provided that the termination shall only apply to the Coverage of that dependent.

- Leaving the Service Area

  - Any Insured who leaves the Health Plan's Service Area with the intent to relocate or establish a new or updated primary residence outside of the Service Area, or any Covered Person who is absent from the Service Area for ninety (90) consecutive calendar days, is deemed to have left the Service Area and will no longer be eligible for Coverage under this Certificate.
  - The Insured is required to notify the Health Plan in writing if the Covered Person leaves the Service Area for the purpose of relocation. However, We may request at any time during the term of the Individual Policy that You provide Us written or electronic verification of Your primary residence within the Service Area.

If a Covered Person's Coverage is terminated by the Health Plan for any reason other than for non-payment of Premium or termination of eligibility, the Health Plan will provide written notification at least forty-five (45) days in advance of the Effective Date of termination. If Your Individual Policy is terminated, the Health Plan will mail written notification within ten (10) business days of the date of termination. This notification will state the date of termination and the reason(s) for termination.

Any termination made under these provisions is subject to review in accordance with the Grievance Procedure described herein.

For Covered Persons enrolled in a plan outside of the Marketplace:

The Insured is required to notify the Health Plan in writing if he or she leaves the Service Area for the purpose of relocation.

For Covered Persons enrolled in a Marketplace plan:

The Insured is required to contact the Marketplace to report a life change if he or she leaves the Service Area for the purpose of relocation.

- Qualified Health Plan ("QHP") Decertification

  The Marketplace may at any time, decertify the Health Plan if it determines that We are no longer in compliance with the general certification requirements. If the Health Plan is decertified, an enrollee's Coverage will be involuntarily terminated. The Marketplace must notify the enrollee in the event the Health Plan is decertified and allow an SEP.

- Annual OEP or SEPs

  During OEP and SEPs, an Insured will be involuntarily terminated from their existing plan when they enroll in a new plan under a different health insurance company's health maintenance organization ("HMO") or state and federally regulated, licensed insurance organization.

TERMINATION DATE OF AN INSURED

An Insured's Coverage will terminate at midnight, Eastern Time, on the date specified by the Health Plan in accordance with the **Termination Provisions** described above. The Insured may have the right to Appeal the decision or find new coverage.

TERMINATION OF A COVERED DEPENDENT

A Covered Dependent's Coverage will automatically terminate at midnight, Eastern Time, on the date specified by the Health Plan for the following reasons:

- The Insured's Coverage terminates for any reason;
- The Covered Dependent fails to continue to meet any of the applicable eligibility requirements;
- Eighteen (18) months after the birth of a Newborn child who is the child of a Covered Dependent child; or
- The Covered Dependent's Coverage is terminated for cause.

For Insureds that enrolled outside of the Marketplace:
In the event the Insured wishes to remove a Covered Dependent from Coverage, the Insured must provide written notice to Us prior to the requested termination date. To request such termination, the required form must be forwarded to Us. You may call Our Customer Service Department to obtain the required form.

To terminate a Covered Spouse's or Covered Domestic Partner's Coverage (e.g., in the case of divorce), the required form must be submitted to Us, prior to the required termination date or within ten (10) calendar days of the date the divorce is final, whichever is applicable. You may call Our Customer Service Department to obtain the required form.

For Insureds that enrolled through the Marketplace:
To terminate a Covered Dependent's Coverage, the Insured must contact the Marketplace to report a life change.

To terminate a Spouse's or Domestic Partner's Coverage through the Marketplace, the Insured must contact the Marketplace to report a life change.

TERMINATION OF A SPOUSE'S OR DOMESTIC PARTNER'S COVERAGE AND/OR A SPOUSE'S OR DOMESTIC PARTNER'S DEPENDENT CHILD'S COVERAGE

In addition to the provision stated in the **Termination of a Covered Dependent** subsection, the Covered Spouse's and the Covered Spouse's Covered Dependent child's Coverage under the Certificate will terminate at midnight, Eastern Time, on the date that the marriage terminates or the date of death of the Spouse. The Covered Domestic Partner's and the Covered Domestic Partner's Covered Dependent child's Coverage under the Certificate will terminate at midnight, Eastern Time, on the date that the Domestic Partnership ends or the date of death of the Domestic Partner.

The Insured must provide notification within ten (10) calendar days of when the Covered Spouse's or Covered Domestic Partner's eligibility requirements are no longer met or the Covered Spouse's or Covered Domestic Partner's death.

For Covered Persons enrolled in a plan outside of the Marketplace:

The Insured must notify the Health Plan, in writing, of the death of the Covered Spouse or Covered Domestic Partner or when the Covered Spouse or Covered Domestic Partner ceases to meet applicable eligibility requirements.

For Covered Persons enrolled in a Marketplace plan:
The Insured must notify the Marketplace of the death of the Covered Spouse or Covered Domestic Partner or when the Covered Spouse or Covered Domestic Partner ceases to meet applicable eligibility requirements.

INSURED'S RESPONSIBILITY FOR NOTIFYING US OF INELIGIBILITY OF COVERED DEPENDENTS

The Insured must notify Us in writing immediately if any Covered Dependent ceases to meet all of the applicable eligibility requirements specified in the **Eligibility** section of this Certificate, but no later than thirty-one (31) calendar days after the Covered Dependent ceases to be eligible for Coverage. If notification of the change is received after the thirty-one (31) day period from the date the Covered Dependent ceases to be eligible, the change will be made effective as of a current date and no Premiums will be refunded.

CONTINUING DEPENDENT COVERAGE ON TERMINATION OF ELIGIBILITY

If Coverage ceases because of termination of eligibility under this Certificate, You shall be entitled to be issued a policy in Your name without evidence of insurability, provided that application is made and Premiums are paid within thirty-one (31) calendar days after termination. There will be continuous Coverage during the thirty-one (31) day period, if such Coverage is selected and the Premiums are paid.

TIME LIMIT ON CERTAIN DEFENSES

"Time Limit on Certain Defenses" is relative to a misstatement in the application. After two (2) years from the issue date, only fraudulent misstatements in the application may be used to void the Coverage or deny any Claims for losses incurred or disability starting after the two (2) year period.

D. CERTIFICATE OF CREDITABLE COVERAGE

The Certificate of Creditable Coverage provides evidence of a Covered Person's Coverage that may be needed when applying for future health coverage. The Certificate of Creditable Coverage will indicate who was Covered under the Health Plan and the period of time the Covered Person was enrolled under the Health Plan. To request a Certificate of Creditable Coverage while Your Coverage is still in force, please contact Our Customer Service Department at 1.855.443.4735 for assistance.

E. RESCISSION OF COVERAGE

We reserve the right to rescind the Coverage under this Certificate as permitted by law. The Health Plan can only rescind the Certificate or Coverage of an individual Covered under this Certificate if You or another person on Your behalf, performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact.

We will provide at least forty-five (45) calendar days advance written notice to You of Our intent to rescind Coverage. Rescission of Coverage is considered an Adverse Determination and is subject to the Appeal procedure described in the **Complaint, Grievance, and Appeal Procedures** section of this Certificate.

F. PREMIUM PAYMENTS

Premiums must be paid in order for this Certificate to effectuate and remain effective. In order to effectuate the Individual Policy, the initial month's Premium must be paid within thirty (30) calendar days of the Effective Date of the Individual Policy. If the initial payment is not received within the required time frame, the Individual Policy will be canceled. Premiums are billed on a monthly basis and must be paid in accordance with established time frames to maintain eligibility. The time frames are included with the billing statement. Premiums are established for the type of Health Benefit Plan. Subject to the approval of the OIR, the Health Plan reserves the right to adjust the Premium charged to an Insured upon the Insured's renewal date, with no less than forty-five (45) calendar days advance notice to the Insured. All Premium adjustments will be deemed accepted by the Insured unless a request for termination is received any time prior to the Effective Date of the adjustment. If such notice requesting termination is received from the Insured, this Certificate will terminate on the date the adjustment would have been effective. The Insured must submit his or her request for disenrollment, in writing, to the Health Plan. Additionally, for Insureds who enrolled through the Marketplace, notice must be provided to the Marketplace.

Premium payments must be made by the Insured, and We will not accept Premium payments from third-party payers except as required by law and as noted below:

- Ryan White HIV/AIDS Program;
- An Indian tribe, tribal organization, or urban Indian organization;
- A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf;
- A designated representative, acceptable to Us, which may include family members and Domestic Partners;
- An Individual coverage Health Reimbursement Arrangement ("HRA") or Qualified Small Employer Health Reimbursement Arrangement ("QSEHRA"); or
- A religious institution or similar, not-for-profit organization, that is acceptable to Us, and only if:
    - The assistance is provided solely on the basis of Your financial need and is not based upon any Condition;
    - The religious institution or organization does not provide Health Care Services and is not a supplier of Health Care Services;
    - The Premium payments cover an entire policy year;
    - The religious institution or organization is not affiliated with an entity that provides Health Care Services or that is a supplier of Health Care Services; and
    - The religious institution or organization does not receive funding from an entity that provides Health Care Services or that is a supplier of Health Care Services.

Please contact the Health Plan's Customer Service Department at 1.855.443.4735 if You have questions as to whether Premium payments from any specific third-party will be accepted.

G. GRACE PERIOD

Qualified individuals receiving an APTC through the Marketplace, have a Grace Period of three (3) consecutive months if the Insured has previously paid at least one (1) month's Premium during the Benefit Year. All other Insureds have a thirty-one (31) calendar day Grace Period if the Insured has previously paid at least one (1) month's Premium during the Benefit Year. This provision means that if any renewal Premium is not paid on or before the date it is due, it may be paid during the Grace Period.

During the Grace Period, Coverage under this Certificate will stay in force. However, if Premium is not paid during the Grace Period, Coverage will terminate as follows:

- If You enrolled through the Marketplace and receive an APTC, the effective date of the termination for non-payment of Premiums will be the last day of the first month of the three (3) month Grace Period.
- If You enrolled through the Marketplace and do not receive an APTC, or you enrolled outside of the Marketplace, the effective date of the termination for non-payment of Premiums will be the last day of the month for which the Premium was paid.

The Health Plan will mail notice of termination to the Certificate Holder forty-five (45) calendar days in advance of the premium due date. The termination effective date will be the initial premium due date.

In no event will termination relieve the Insured of his/her obligation under this Certificate to pay Us any prorated portion of the Premium applicable to the period of time during which We have provided benefits, or for any amounts otherwise due to Us. The Insured will receive at least ten (10) days' notice, including the reason for termination, prior to the end of the Grace Period.

For an Insured receiving an APTC and who is within the three (3) month Grace Period, the Health Plan may pend Claims for Medical Services and Prescription Drugs rendered during the second and third months of the Grace Period. If the Insured fails to pay the Premium before the end of the Grace Period, the Health Plan may then deny any Claims that were pended during the second and third months of the Grace Period.

Reinstatement: If the renewal Premium is not paid before the Grace Period ends, the Individual Policy will lapse. Later acceptance of the Premium by the Health Plan, or by an agent authorized to accept payment without requiring an application for reinstatement, will reinstate this Individual Policy. If the Health Plan or its agent requires an application, the Insured will be given a conditional receipt for the Premium. If the application is approved, the Individual Policy will be reinstated as of the approval date. Lacking such approval, the Individual Policy will be reinstated on the forty-fifth (45th) day after the date of the conditional receipt unless the Health Plan has previously written the Insured of its disapproval. The reinstated Individual Policy will Cover only loss that results from an Injury sustained after the date of reinstatement or Sickness that starts more than ten (10) days after such date. In all other respects, the rights of the Insured and the Health Plan will remain the same, subject to any provisions noted on or attached to the reinstated Individual Policy. Any Premiums the Health Plan accepts for a reinstatement will be applied to a period for which Premiums have not been paid.

H. DISCRETIONARY AUTHORITY

The Health Plan, in accordance with the ACA, has the discretionary authority to determine eligibility, to construe terms of this Certificate, and to make decisions concerning Claims for benefits under the terms of this Certificate. The Health Plan may delegate this discretionary authority to other persons or entities with request to the administration of this Certificate.

Under certain circumstances, the Health Plan, at its sole discretion, may occasionally offer benefits for Services that are otherwise not Covered Services under this Certificate, and doing so in a particular case does not require the Health Plan to do so in any other case.

I. CONFORMITY WITH STATE STATUTES

Any provision of this Individual Policy, which, on its Effective Date, is in conflict with the statutes of the State of Florida, is hereby amended to conform to the minimum requirements of such statutes.

J. PROVISION OF INDIVIDUAL HEALTH INSURANCE POLICIES

In the absence of fraud, all statements made by Applicants or by a Covered Person shall be deemed representations and not warranties. No statement made for the purpose of effecting

insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the Applicant or Covered Person, a copy of which has been furnished to such Covered Person or his or her beneficiary.

K. PROOF OF LOSS

Written proof of loss must be given to the Health Plan within ninety (90) days after the end of each period for which the insurer is liable. For any other loss, written proof must be given within ninety (90) days after such loss. If it was not reasonably possible to give written proof in the time required, the Health Plan shall not reduce or deny the Claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one (1) year from the time specified unless the Covered Person was legally incapacitated.

III. COVERAGE PROVISIONS

This section provides important information about the Coverage of Health Care Services provided under this Certificate, explaining:

- Guidelines the Covered Person(s) must follow in accessing care;
- The Services and supplies that are Covered; and
- The Services and supplies that are excluded from Coverage.

It is important to remember that exclusions and limitations specific to a type of Service or supply are included along with the benefit description in the **Covered Services** section, and these exclusions and limitations also apply to Your Coverage. Additional exclusions and limitations that may apply can be found within the **Exclusions and Limitations** section. More than one (1) limitation or exclusion may apply to a specific Service or a particular situation. Preexisting exclusions do not apply.

Expenses for the Health Care Services listed in the **Covered Services** section will be Covered under this Certificate only if the Services are:

- Within the Covered Services categories in the **Covered Services** section of this Certificate;
- Actually rendered to You (not just proposed or recommended) by an appropriately licensed Health Care Provider who is recognized for payment by Us and for which We receive an itemized statement or description of the procedure or Service which was rendered, including any applicable procedure code, diagnosis code, and other information We require in order to process a Claim for Service;
- Medically Necessary, as defined in this Certificate by Us in accordance with Our Medical Necessity Coverage criteria then in effect, except as specified in this section;
- In accordance with Our benefit guidelines listed in the **Covered Services** section;
- Rendered while Your Coverage is in force;
- Medical Services and supplies that are not prescribed or ordered by, nor provided by, Yourself or any person related to You by blood, marriage, Adoption, or Domestic Partnership; and
- Not specifically or generally limited or excluded under this Certificate.

In general, We will determine whether Services are Covered Services under this Certificate after You have obtained the Services and We have received a Claim for the Services. However, in some circumstances, We may determine whether Services might be Covered Services under this Certificate before such Services are rendered. For example, We may determine whether a proposed surgery would be a Covered Service under this Certificate before the surgery is provided. We are also not obligated to Cover or pay for any Service that has not actually been rendered to You.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS ON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND, OR ALTER THE COVERAGE REPORTED BY THE POLICY DESCRIBED HEREIN.

In determining whether Health Care Services are Covered Services under this Certificate, no written or verbal representation by an employee or agent of the Health Plan or by any other person shall waive or otherwise modify the terms of this Certificate and the Individual Policy described herein.

For information on Prescription Drug Coverage, please refer to the **Health Plan's Pharmacy Program** section of this Certificate.

COVERAGE ACCESS GUIDELINES

It is important that Covered Persons become familiar with the guidelines for accessing Health Care Services through the Health Plan. The following sections explain the role of the Health Plan and the Physician. The following sections also describe how to access primary and specialty care through the Health Plan, what to do if Emergency Services or Urgent Care are needed, and the Prior Authorization provision.

A. CHOOSING A PRIMARY CARE PHYSICIAN ("PCP")

Under Your Individual Policy, You are not required to select a PCP before Services are Covered. You are free to seek an appointment with any Network Provider who is not Yourself or related to You by blood, marriage, Adoption, or Domestic Partnership.

We encourage You to use Our Network of Participating PCPs to help You coordinate Your care and to help You navigate the care provided by Participating Network Specialists and Participating Network Facilities within Your Health Plan Provider Network.

Although You are not required to select a PCP upon enrollment, the Health Plan strongly recommends that You do so. You are free to choose any PCP from the published list of PCPs whose practices are open to new patients. PCPs may be Medical Doctors ("MDs"), Doctors of Osteopathy ("DOs"), Advanced Practice Registered Nurses ("APRNs"), or Physician Assistants ("PAs"). Covered Persons may select as their PCP an Obstetrician/Gynecologist ("OB/GYN") who has agreed to serve as a PCP and is in the Health Plan's Provider Network. Please note: The OB/GYN acting as a PCP must agree to be reimbursed at a PCP rate. Selecting a PCP does not prevent You from obtaining care elsewhere in the Network, and referrals are not required to access specialty care. A relationship with a PCP can enhance the quality of medical care received through coordination and direction of all necessary medical Services. The Covered Person should look to the PCP to direct their care and should consider procedures and/or treatment recommended by the PCP.

B. CONTINUITY OF CARE

If a Participating Provider terminates his or her agreement with the Health Plan or is terminated by the Health Plan for any reason other than for cause, a Covered Person receiving active treatment may continue Coverage and care with that Provider when Medically Necessary and through completion of treatment of a Condition for which the Covered Person was receiving care at the time of the termination. Access to such terminated Provider for active treatment may continue:

- Through the current period of active treatment or for up to ninety (90) calendar days, whichever is less, after termination of the Participating Provider's agreement with the Health Plan; or
- In the case of a pregnant Covered Person who has initiated a course of prenatal care with the terminated Provider, care may continue through the postpartum period, which is up to

six (6) weeks following the birth. All continuation of care must be coordinated and authorized according to the provisions of this Individual Policy to ensure proper Coverage.

A Provider (PCP or Specialist) may refuse to continue providing care to a Covered Person who is abusive, non-compliant, or in arrears in payment for Services provided.

A Covered Person in active course of treatment should contact the Health Plan to assist in coordinating continued Coverage with the terminated Provider or affecting the transfer to another Participating Provider. Prior Authorization for continuation of care with a terminated Provider is required for all Covered Persons in order for the Services to be Covered by the Health Plan.

C. ACCESSING SPECIALTY CARE

The Health Plan does not require a Covered Person to obtain a referral from the PCP prior to seeking Services from a participating Specialist. However, some participating Specialists will not accept appointments directly from Covered Persons that have not been "referred" for care by their PCP. In these instances, a Covered Person will first need to see a PCP. Although the Health Plan operates as an "Open Access" HMO, We strongly recommend that Covered Persons coordinate all care they are receiving from a Specialist with their PCP.

If a non-participating Specialist is required because Medically Necessary Services are not available within the Participating Provider Network, the PCP or non-participating Specialist will submit a request for Authorization of Coverage for such treatment to the Health Plan. In this situation, You will pay the same as You would pay if You received the care within the Participating Provider Network. Please contact Your PCP to help coordinate these Services.

Prior Authorization is required for all Services and supplies received from a Non-Participating Provider, except for Emergency Services and Out-Of-Area Urgent Care. If such Out-of-Network Services and supplies are not authorized in advance by the Health Plan, whether referred by the Participating Provider or not, the Covered Person will not have Coverage for the Services or supplies.

D. PRIOR AUTHORIZATION

In order for certain Services to be Covered, Prior Authorization by the Health Plan is required. This provision includes Services such as Inpatient care, diagnostic and medical procedures, Out-Of-Network Services (except for Emergency Medical Conditions or Urgent Care), and certain pharmaceutical Services. If Services requiring Prior Authorization are obtained without proper Authorization, the Covered Person may be responsible for the entire cost. Services requiring Prior Authorization are subject to change without prior notice and at the sole discretion of the Health Plan. The list of Services subject to Prior Authorization can be accessed online at hf.org/healthplans.

When Prior Authorization is required, the Participating Provider must submit the written Authorization request via the online Provider portal (if the Provider is an In-Network Provider) or via fax request (if the Provider is an Out-of-Network Provider) with supporting clinical information to the Health Plan for review. The Provider requesting the Authorization will be considered an authorized representative of the Covered Person during the Prior Authorization process. All related communications will be directed from the Health Plan to the requesting Physician, who will communicate with the Covered Person. If Authorization is denied for any reason, both the Covered Person and the requesting Physician will receive a notice explaining the reason for the denial and the process for filing an Appeal.

EXPEDITED AUTHORIZATIONS

If the Covered Person's life or ability to regain maximum functioning would be jeopardized by applying the standard decision time frame, an expedited Authorization process is available. For expedited requests, a decision will be made and communicated within seventy-two (72) hours. If

additional information is required in order to make a decision, this time frame may be extended an additional forty-eight (48) hours after allowing forty-eight (48) hours for the Provider or Covered Person to submit the necessary information.

STANDARD PRE-SERVICE AUTHORIZATIONS

For standard Authorization requests, a decision will be made and communicated within fifteen (15) calendar days. If additional information is required in order to make a decision, this time frame may be extended an additional fifteen (15) calendar days after allowing forty-five (45) calendar days for the Provider or Covered Person to submit the necessary information.

E. EMERGENCY AND URGENT CARE SERVICES

EMERGENCY SERVICES AND CARE

In the event of an Emergency Medical Condition, Covered Persons should seek care at the closest medical Facility available without regard to the Network participation status of the Facility. Emergency Services for treatment of an Emergency Medical Condition are Covered In-Network and Out-of-Network, including locations outside the United States and its territories, without the need for Prior Authorization from the Health Plan. An Emergency Medical Condition is defined as:

- A medical Condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
  - Serious jeopardy to the health of a patient, including a pregnant woman or a fetus;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- With respect to a pregnant woman:
  - That there is inadequate time to effect safe transfer to another Hospital prior to delivery;
  - That a transfer may pose a threat to the health and safety of the patient or fetus; or
  - That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency Inpatient, outpatient, and Physician Services are available on a twenty-four (24) hour, seven (7) day a week basis. Emergency resuscitation supplies, Physicians, and other health care practitioners shall be readily available at all times.

Coverage will be provided for medical screening, examination, and evaluation by a Physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Physician, to determine if an Emergency Medical Condition exists. The determination that an Emergency Medical Condition exists, shall be made for the purposes of the care, treatment, or surgery for a Covered Service by a Physician to relieve or eliminate the Emergency Medical Condition, within the service capability of a Hospital, is Covered. If care is sought for a non-Emergency Medical Condition, payment shall be limited to costs for the determination of whether an Emergency Medical Condition existed, and no further benefits will be paid.

In the event of an Emergency Medical Condition, the Covered Person or the Covered Person's family should notify the Health Plan as soon as reasonably possible. Only the initial treatment, as described above, is Covered without Authorization at non-participating Facilities. All follow-up care must be coordinated and Authorized to ensure proper Coverage under this Certificate.

All follow-up care must be coordinated and authorized according to the provisions of this Individual Policy to ensure proper Coverage under this Certificate.

Payment Rules for Emergency Services and Care

Payment for Emergency Services and Care rendered by a Non-Participating Provider that has not entered into an agreement with the Health Plan to provide access at a discount from the billed amount of that Provider, shall be:

- The contract status of the Non-Participating Provider will be verified with the Health Plan's extended Network. If the Provider is contracted with the extended Network, the Claim will be reimbursed based on that contract;
- The charge mutually agreed to by the Health Plan and the Provider within sixty (60) days of the Claim submittal utilizing the Medicare Allowable amount as guidance;
- The median of the contracted rate on January 31, 2019 for the same or similar items or Service, increased for inflation according to the Qualified Payment Amount ("QPA") calculation methodology; or
- Lesser of the Provider's billed charges.

Such payment shall be the net of any applicable Cost-Share.

This Individual Policy also Covers Emergency Services outside the United States and its territories up to the Medicare Allowed Amount in the Health Plan's Service Area, less any applicable Cost-Sharing amounts. The Covered Person will be responsible for any charges that exceed the Medicare Allowable.

When Emergency and Urgent Care Services are received outside the United States and its territories, the Covered Person will be responsible for the Health Care Provider's charges at the time the Services are rendered. The Covered Person may submit a request for medical reimbursement to the Health Plan. Refer to the **Claim Provisions** section of this Certificate for more information on how to file a Claim for benefits. Reimbursement for out-of-country Emergency and Urgent Care Services shall be limited to the local Medicare Allowable, minus the Covered Person's Cost-Share.

URGENT CARE

Urgent Care Services are Covered both inside and outside the Health Plan Network. Applicable Cost-Share amounts for both In-Network and Out-of-Network Coverage are listed in the Schedule of Benefits attached to this Certificate.

Inside the Service Area, Covered Persons must utilize participating Urgent Care Centers. Outside the Service Area, Coverage is provided at a Non-Participating Urgent Care Center. Urgent Care Coverage is limited to care for Conditions, which, although not life threatening, could result in serious health consequences if not treated within twelve (12) hours and were unforeseeable prior to leaving the area.

This Individual Policy also Covers Urgent Care Services outside the United States and its territories up to the Medicare Allowed Amount in the Health Plan's Service Area, less any applicable Cost-Sharing amounts. The Covered Person will be responsible for any charges that exceed the Medicare Allowable.

F. MEDICAL PAYMENT GUIDELINES FOR NON-PARTICIPATING PROVIDER CARE

The Health Plan's payment for Covered Services will be limited by the Medical Payment Guidelines in effect, when the Covered Person requires Medically Necessary care from a Non-Participating Provider and the care has been authorized in advanced, when applicable. These guidelines include the following:

- The payment of expenses for Covered Services received from Non-Participating Providers is limited to payment for the most cost-effective procedures, treatment,

Services, and supplies that are provided in the most cost-effective setting. For example, Services are limited to the most cost-effective Prosthetic Device, Orthotic Device, or Durable Medical Equipment ("DME") that will restore to the Covered Person the function lost due to the Condition;

- Payments for many Services and/or supplies are included within the Allowance for the primary procedure; therefore, no additional amount is payable by the Health Plan or the Covered Person for certain Services and/or supplies. The Health Plan follows Medicare guidelines regarding separate payment for Services and payment reductions for multiple procedures; and
- The Health Plan's payment is based on the In-Network Allowed Amount for the actual Service rendered (for example, not based on the Allowed Amount for a Service which is more complex than the Service actually rendered), and is not based on the method utilized to perform the Service nor the day of the work or time of day the procedure is performed. For example, charges for after-hours care are not Covered.

All Services and supplies received by Covered Persons must be rendered by In-Network Providers in order to be Covered (except in the case of Emergency Services or Urgent Care). This is true even when the Services or supplies received are Medically Necessary. However, if a Covered Person requires care that is not available within the Health Plan's Provider Network, arrangements will be made by the Health Plan to provide the appropriate care elsewhere. In these instances, and when the proper Prior Authorization is obtained from the Health Plan, Covered Persons shall be responsible for the appropriate In-Network Cost-Share.

G. EXTENSION OF BENEFITS UPON REPLACEMENT OF THE HEALTH PLAN

The prior health insurance plan may be required to provide certain benefits to certain Covered Persons under an extension of benefits provision. In no event under this Individual Policy shall the Health Plan pay any Claims for Services or supplies that are covered under any provision with the prior health plan relating to extension of benefits, until the extension of benefits for the Condition under the prior plan ends for the Covered Person, when applicable.

IV. COVERED SERVICES

This section describes the Services and supplies that are Covered under this Individual Policy. It is important that You review this whole section, along with the **Exclusions and Limitations** section that follows, to be sure both Covered Service details and the limitations and exclusions are understood. In addition, important information is contained in the Schedule of Benefits attached to this Certificate.

All of these provisions should be read carefully to understand the benefits provided under this Individual Policy.

COVERED SERVICES CATEGORIES

The Services and supplies listed below will be considered Covered Services under this Individual Policy if the Service or supply is:

- Set forth within the **Covered Services** categories in this section;
- Authorized and approved by the Health Plan in advance of receiving the Services or supplies, except for Urgent or Emergency Services and Care, when such Services and supplies are subject to a Prior Authorization requirement (see the **Prior Authorization** section of this Certificate for more information);
- Received from a Participating Provider as published in the Provider/Pharmacy Directory, except for Urgent or Emergency Services and Care;
- Actually rendered while Coverage under this Individual Policy is in force;

- Medical Services and supplies that are not prescribed or ordered by, nor provided, by Yourself or any person related to You by blood, marriage, Adoption, or Domestic Partnership;
- Medically Necessary, as defined in this Certificate; and
- Not specifically limited or excluded under this Certificate.

Covered Persons are responsible for the Cost-Share listed in the attached Schedule of Benefits for each category of Covered Services.

Acute Inpatient Rehabilitation Facility Services
Acute Inpatient Rehabilitation Facility Services are Covered when considered Medically Necessary and authorized in advance by the Health Plan. Services are subject to the applicable Inpatient Facility Cost-Share amount and the benefit maximum of twenty-one (21) days per Calendar Year as set forth in the Schedule of Benefits.

Alcohol and Substance Use Disorder ("SUD") Treatment
Alcohol and SUD treatment Services and supplies provided by, or under the supervision of, or prescribed by a licensed Physician or licensed Psychologist, are Covered when considered Medically Necessary and may require Prior Authorization. The program must be accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the State of Florida for the treatment of alcohol or Drug dependency. The Services Covered are as follows:

- Inpatient treatment for the acute stages of SUD or Detoxification provided in a general specialty or Rehabilitative Hospital; and
- Outpatient care Services provided or prescribed by, or under the supervision of, a licensed Physician or licensed Psychologist. Detoxification Services and supplies are not Covered Services when provided on an outpatient basis.

Allergy Testing and Treatments
Testing, desensitization therapy (e.g., injections), and the cost of hyposensitization serum are Covered when considered Medically Necessary. The Allowed Amount for allergy testing is based upon the type and number of tests performed by the Physician. The Allowed Amount for allergy immunotherapy treatment is based upon the type and number of doses.

Ambulance Services
Emergency Ambulance transportation by a licensed Ambulance Service (either ground, air Ambulance, or water vehicle) to the nearest Facility where the required Health Care Services to treat the Emergency Medical Condition can be performed is Covered. Prior Authorization is not required for emergency Ambulance transportation. Applicable Cost-Sharing will apply for each Covered trip (one-way).

Non-emergency Ambulance transportation by a licensed Ambulance Service (either ground or air Ambulance, as the Health Plan determines appropriate) between Facilities is Covered when Medically Necessary and authorized in advance by the Health Plan. Medical Necessity is established when the Covered Person's Condition is such that use of any other method of transportation could endanger the person's health. No payment will be made for Ambulance Services when an alternate means of transportation, that would not endanger the individual's health, was available.

Ambulance Services are provided for emergency (does not require Prior Authorization) and non-emergency situations, when Medically Necessary and authorized in advance.

Ambulance Services by boat, airplane, or helicopter are Covered as described above, and will be reimbursed at the Allowed Amount level when:

- The pick-up point is inaccessible by ground transportation;

- Speed in excess of ground vehicle speed is critical; or
- The travel distance involved in getting the Covered Person to the nearest Hospital that can provide proper care is too far for medical safety.

Ambulance Services provided without transfer to a Facility are not Covered. Ambulance transportation outside of the United States or its territories is not Covered.

Ambulatory Surgical Centers Services and Other Outpatient Medical Treatment Facilities
The Services and supplies listed below that are provided to a Covered Person at an Ambulatory Surgical Center or other outpatient medical treatment Facility will be considered Covered Services when considered Medically Necessary, authorized, and obtained in accordance with all other plan provisions included herein:

- Use of operating and recovery rooms;
- Respiratory or inhalation therapy (e.g., oxygen);
- Drugs and medicines administered at the Ambulatory Surgical Center or other outpatient medical treatment Facility (except for take home Drugs);
- Intravenous solutions;
- Dressing, including ordinary casts, splints, or trusses;
- Anesthetics and their administration;
- Administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the **Exclusions and Limitations** section);
- Transfusion supplies and equipment;
- Diagnostic Services, including radiology, ultrasound, laboratory, pathology, and approved machine testing (e.g., electrocardiogram ("EKG"));
- Imaging Services, including computerized tomography ("CT") scans, Magnetic Resonance Imaging ("MRI"), and Positron Emission Tomography ("PET") scans (separate Cost-Share applies);
- Chemotherapy treatment for proven malignant disease; and
- Other Medically Necessary Services and supplies.

Anesthesia Administration Services
Anesthesia Services are Covered when administered by a Health Care Provider, including a Certified Registered Nurse Anesthetist, and necessary for a surgical procedure. Anesthesia Services provided in connection with a Preventive colonoscopy are considered a Preventive Health Service and are not subject to Cost-Share as set forth in the Schedule of Benefits.

Autism Services and Treatment
Autism Services and treatment are covered when Medically Necessary. In addition to well-baby and well-child screening for diagnosis purposes, Coverage is provided for the treatment of Autism Spectrum Disorder through Speech Therapy ("ST"), Occupational Therapy ("OT"), Physical Therapy ("PT"), and Applied Behavior Analysis ("ABA"). ABA Services shall be provided by an individual certified pursuant to Chapter 393 of the Florida Statutes or an individual licensed under Chapter 490 or Chapter 491 of the Florida Statutes. Coverage shall be limited to treatment that is Medically Necessary and prescribed in accordance with a treatment plan approved by the Health Plan and may not be denied on the basis that Services are habilitative in nature. A Covered Person will need to follow Health Plan guidelines for accessing Services.

All therapy Services to treat Autism Spectrum Disorder must be considered Medically Necessary and authorized in advance by the Health Plan.

Biofeedback Services

Biofeedback Services are Covered when considered Medically Necessary and authorized in advance by the Health Plan.

Blood
Coverage includes whole blood, blood plasma, blood components, and blood derivatives, unless replaced.

Breast Cancer Treatment
Coverage for breast cancer treatment includes Inpatient Hospital care and outpatient post-surgical follow-up care for Mastectomies when Medically Necessary in accordance with prevailing medical standards. Prior Authorization may be required. Coverage for outpatient post-surgical care is provided in the most medically appropriate setting, which may include the Hospital, treating Physician's office, outpatient center, or the Covered Person's home. Inpatient Hospital treatment for Mastectomies will not be limited to any period that is less than that determined by the Participating Physician.

Coverage for Mastectomies includes:

- All stages of reconstruction of the breast incident to the Mastectomy;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of Mastectomy, including lymphedemas.

Breast Reduction Services
Breast reduction Services may be considered Medically Necessary when the Covered Person's Condition is such that it causes significant clinical manifestations. These Services may require Prior Authorization.

Cancer Diagnosis and Treatment
Cancer diagnosis and treatment Services are Covered when considered Medically Necessary and may require Prior Authorization, unless otherwise excluded, on an Inpatient or outpatient basis, including chemotherapy treatment, x-ray, cobalt, and other acceptable forms of radiation therapy, microscopic tests, or any lab tests or analysis made for diagnosis or treatment.

Cancer Screenings
Cancer screenings recommended by the United States Preventive Services Task Force ("USPSTF") with an "A" or "B" rating are Covered as Preventive benefits with no Cost-Share. Current recommendations address breast, cervical, lung, and colorectal cancers. Prostate cancer screening (e.g., prostate specific antigen ("PSA") test) is Covered without Cost-Sharing. Skin cancer screenings are Covered with applicable Cost-Sharing amounts. Frequency and age limits established by the USPSTF or the Health Plan apply.

Casts and Splints
Casts and splints are Covered when part of the treatment provided in a Health Care Provider Facility, Provider office, or in a Hospital emergency room. This does not include the replacement of any of these items.

Chimeric Antigen Receptor, T cell (CAR-T) Therapy

CAR-T Cell Therapy is Covered for U.S. Food and Drug Administration ("FDA") approved uses when considered Medically Necessary and authorized in advance by the Health Plan.

Cleft Lip and Cleft Palate Treatment
Health Care Services for cleft lip and cleft palate, including medical, dental (that are not Covered under the Covered Person's dental plan), ST, audiology, and nutrition Services, for treatment of a Covered Person who has cleft lip or cleft palate, are Covered when considered Medically

Necessary and are authorized in advance. Any ST Coverage provided is subject to the limitation set forth in Your Schedule of Benefits for outpatient rehabilitation Services. In order for such Services to be Covered, the Covered Person's Physician must specifically prescribe such Services, and such Services must be consequent to treatment of the cleft lip or cleft palate.

Clinical Trials
Covered routine costs associated with clinical trials include items or Services typically provided in absence of a clinical trial when provided or administered in a way that is considered standard for the Condition being treated. Routine costs include expenses for items and Services provided in either the experimental or control arm of a clinical trial that would otherwise be Covered under the plan.

Routine costs associated with clinical trials may be Covered:

- When eligibility requirements are met;
- Subject to Coverage provisions, limitations, and exclusions;
- When Prior Authorization is received for Services that require Prior Authorization in advance; and
- When received from Participating Providers when required in order to participate in the trial. Covered Persons must receive Prior Authorization from the Health Plan for Services rendered by a Non-Participating Provider in order for the Services to be Covered.

The following are not considered routine costs and are not Covered:

- The investigational item or Service itself. This includes items or Services that would ordinarily be considered standard but are used in an experimental fashion;
- Items and Services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- Items and Services customarily provided by the research sponsors free of charge for any enrollee in the trial; and
- Complications resulting from participation in a clinical trial.

Concurrent Physician Care
Concurrent Physician care Services are Covered for approved procedures, including surgical assistance, provided:

- The additional Physician actively participates in the Covered Person's treatment;
- The Condition involves more than one (1) body system or is so severe or complex that one (1) Physician cannot provide the care unassisted; and
- The Physicians have different specialties or have the same specialty with different sub-specialties.

Congenital and Developmental Abnormality
Congenital and development abnormality Services are Covered provided the treatment or plastic and Reconstructive Surgery is for the restoration of bodily function or the correction of a deformity resulting from disease or congenital or developmental abnormalities. Prior Authorization may be required.

Consultations
Consultations provided by a Physician are Covered, provided the Covered Person's treating Physician requests the consultation and the consulting Physician prepares a written report.

Contraceptive Services (See Family Planning)

Dental Services
Certain Dental Services may be Covered with Prior Authorization and are limited to the following:

- Care and stabilization treatment rendered within sixty-two (62) calendar days of an Accidental Dental Injury, provided such Services are for the treatment of damage to Sound Natural Teeth;
- Extractions of teeth to prepare the jaw for required radiation treatment of neoplastic disease, and for an oral or dental examination performed on an Inpatient basis as part of a comprehensive workup prior to renal Transplant surgery, or prior to a heart valve replacement; and
- Anesthesia Services for dental care, including general anesthesia and hospitalization Services, necessary to assure the safe delivery of necessary dental care provided to You in a Hospital or Ambulatory Surgical Center if:
    - A Covered Person has one (1) or more medical Conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center; or
    - A Covered Dependent under age eight (8) years of age who's treating Physician, in consultation with the Dentist, determines necessary dental treatment is required in a Hospital or Ambulatory Surgical Center due to a significantly complex dental Condition or a developmental disability in which patient management in the dental office has proven to be ineffective.

Necessary dental treatment is that which, if left untreated, is likely to result in a medical Condition. The Health Plan must authorize the use of general anesthesia and Hospital Services prior to the treatment. Coverage does not include diagnosis or treatment of dental disease, or the Services of the Dentist or oral surgeon, except as described above.

The above Covered Services are separate from the Pediatric Dental Benefits described in this Certificate. Please see the **Pediatric Dental Benefits** section for additional Coverage information and requirements.

Dermatological Services
Dermatological Services are Covered and include dermatological office visits or minor procedures and testing. Services or testing not considered minor or routine in nature may be Covered when considered Medically Necessary and may require Prior Authorization.

Diabetes Outpatient Self-Management Services
Diabetes outpatient self-management training and educational Services and nutrition counseling (including all Medically Necessary equipment and supplies) to treat diabetes, are Covered when obtained from Participating Providers. The Covered Person's treating Physician who specializes in treating diabetes must certify that the equipment, supplies, or Services are Medically Necessary. In order to be Covered, diabetes outpatient self-management training and educational Services must be provided under the direct supervision of a certified Diabetes Educator or a board certified Physician specializing in endocrinology at an approved Facility. Additionally, in order to be Covered, a licensed Dietitian must provide nutrition counseling. Covered Services may also include the trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease, subject to Cost-Share requirements.

Diagnostic and Surgical Procedures Involving Bones or Joints of the Jaw
Diagnostic and surgical procedures involving bones or joints of the jaw and facial region are Covered if, under acceptable medical standards, such procedure or surgery is Medically Necessary to treat Conditions caused by congenital or developmental deformity, disease, or Injury. Intra-oral Prosthetic Devices are also Covered when authorized in advance.

Diagnostic Services
Coverage of diagnostic Services, when ordered by a Physician, are Covered when considered Medically Necessary and may require Prior Authorization. Diagnostic Services are limited to the following:

- Radiology, ultrasound, nuclear medicine, and imaging Services;
- Laboratory and pathology Services;
- Services involving bones or joints of the jaw (e.g., Services to treat temporomandibular joint ("TMJ") dysfunction) or facial region if, under accepted medical standards, such diagnostic Services are necessary to treat Conditions caused by congenital or developmental deformity, disease, or Injury;
- Approved machine testing (e.g., EKG, electroencephalograph ("EEG"), and other electronic diagnostic medical procedures); and
- Genetic Testing as provided in the **Covered Services** section.

Dialysis Services
Dialysis Services, including hemodialysis and peritoneal dialysis, are Covered, including equipment, training, and medical supplies required for home dialysis or when provided on an outpatient basis (e.g., at the Hospital, at a Dialysis Center, or in a Physician's office) by a contracted Provider licensed to perform dialysis.

Down Syndrome Services and Treatment
Coverage for Down syndrome Services and treatment is limited to a Covered Person under eighteen (18) years of age, or a Covered Person eighteen (18) years of age or older who is in high school and who has been diagnosed by a qualified Provider approved by the Health Plan as having Down syndrome by age eight (8) years or younger. In addition to well-baby and well-child screening for diagnosis purposes, Coverage is provided for the treatment of Down syndrome through ST, OT, PT, and ABA. ABA Services shall be provided by an individual certified pursuant to Chapter 393 of the Florida Statutes or an individual licensed under Chapter 490 or Chapter 491 of the Florida Statutes. Coverage shall be limited to treatment that is Medically Necessary and prescribed in accordance with a treatment plan approved by the Health Plan and may not be denied on the basis that Services are habilitative in nature. A Covered Person will need to follow Health Plan guidelines for accessing Services.

All therapy Services to treat Down syndrome must be considered Medically Necessary and may require Health Plan Authorization.

Durable Medical Equipment ("DME")
DME is Covered when provided by a DME Provider and determined by the Covered Person's treating Physician to be Medically Necessary for the care and treatment of a Condition Covered under this Certificate. DME is Covered when considered Medically Necessary and may require Prior Authorization. The specified DME will not, in whole or in part, serve as a comfort or convenience item for the Covered Person or be available Over-the-Counter ("OTC"). Supplies and Services to repair medical equipment may be a Covered benefit only if the Covered Person owns the equipment or is purchasing the equipment under a maintenance agreement with the Health Plan. The Health Plan's Allowance for DME is based on the most cost-effective DME that meets the Covered Person's needs, as determined by the Health Plan. At the Health Plan's option, the cost of either renting or purchasing will be Covered. If the cost of renting is more than its purchase price, only the cost of the purchase is considered a Covered Service.

Repair or replacement of DME due to growth of a child or significant change in functional status is a Covered Service.

Insulin Pumps and Continuous Glucose Monitors are Covered when Medical Necessity criteria is met.

Emergency Services
Emergency Services for an Emergency Medical Condition are Covered In-Network and Out-of-Network without Prior Authorization.

When Emergency Services for an Emergency Medical Condition are provided by an Out-of-Network Provider, any Copayment and/or Coinsurance amount applicable to In-Network Providers for Emergency Services will also apply to the Out-of-Network Provider.

This Individual Policy also Covers Emergency Services outside the United States and its territories up to the Medicare Allowed Amount in the Health Plan's Service Area, less any applicable Cost-Sharing amounts. The Covered Person will be responsible for any charges that exceed the Medicare Allowable Amount.

Enteral/Parenteral and Oral Nutrition Therapy
Enteral and Parenteral Nutrition is Covered when considered Medically Necessary by the Health Plan and authorized in advance. Oral nutrition prescribed by a Physician is Covered for Covered Persons with inborn errors of metabolism or inherited metabolic diseases, and include phenylketonuria ("PKU"). Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein when prescribed by a Physician. Oral nutrition therapy of any other kind, or when taken for any other reason, is not considered Medically Necessary.

Erectile Dysfunction Treatment
Treatment of erectile dysfunction caused by a physical Condition is Covered when considered Medically Necessary and authorized in advance by the Health Plan. Erectile dysfunction Drugs are excluded under applicable Prescription Drug Coverage. Refer to the **Covered Services** section of this document.

Family Planning
The following family planning Services and supplies are Covered as a Preventive benefit:

- Contraceptive methods approved by the FDA and prescribed by a Physician including Physician-prescribed barrier methods, hormonal methods, implanted devices, and surgical methods (temporary and permanent);
- Contraceptive counseling;
- Initiation of contraceptive use;
- Contraceptive use follow-up care (e.g., management and evaluation, as well as changes to and removal or discontinuation of the contraceptive method); and
- FDA-approved OTC items when prescribed by a Physician.

Note: Vasectomies are not Covered as a Preventive benefit and are subject to Cost-Sharing.

Fitness Center Membership
Fitness center membership is Covered under some plans to assist Covered Persons with maintaining or improving their health status. The Health Plan offers a fitness center membership to Covered Persons exclusively at fitness centers contracted as Participating Providers. Please refer to Your Schedule of Benefits to see if Your plan includes a fitness center membership benefit. A Physician release may be required prior to accessing this benefit, and continued eligibility for this program is subject to separate rules of conduct as established by the Participating Facilities. Age limitations may apply for other participating fitness centers.

Foot Care

Routine foot care services are covered when medically necessary. This may include trimming of toenails, corns, calluses, and therapeutic shoes for the treatment of severe diabetic foot disease.

Foot Orthotics
The Health Plan will Cover the original arch support or Orthotic Device/appliance, and replacement of the device, for children under the age of nineteen (19) if the original need for the device/appliance was for congenital deformity and if the replacement is due to growth or change. Foot Orthotics are Covered when considered Medically Necessary and may require Prior Authorization.

Genetic and Chromosomal Testing and Counseling
Genetic and chromosomal testing is Covered when considered Medically Necessary and authorized in advance by the Health Plan. In general, such testing is considered Medically Necessary when the test has proven analytical and clinical validity and the results are necessary for the immediate decision about treatment options for the Covered Person. When testing for inheritable diseases, the individual must be at risk of carrier status (as supported by existing peer-reviewed, evidence-based, scientific literature) for the presence of a genetically-linked inheritable disease, with testing performed to possibly identify a specific genetic mutation that may affect clinical outcomes based on existing peer-reviewed, evidence-based, scientific literature. BRCA Analysis to determine a woman's genetic risk for breast and ovarian cancer is Covered as a Preventive benefit when Medical Necessity criteria are met.

Genetic Counseling is considered Medically Necessary and Covered when in conjunction with Medically Necessary Genetic Testing.

Hearing Devices
Cochlear implants, auditory implants, and bone anchored hearing aids may be Covered if Medically Necessary and authorized by the Health Plan in advance. For additional information regarding hearing aids, please see the **Health Care Services Exclusions** section of this Certificate.

Hearing Services
Diagnostic hearing and balance evaluations performed by Your Provider to determine if You need medical treatment are Covered when provided by a Physician, audiologist, or other qualified Provider.

Home Health Care
The Home Health Care Services listed below are Covered when all of the following criteria are met:

- You are unable to leave Your home without considerable effort or the assistance of another person because You are bedridden or chair bound, restricted in ambulation (whether or not You use assistive devices), or significantly limited in physical activities due to a Condition;
- The Home Health Care Services rendered have been prescribed by a Physician by way of a formal written treatment plan, which has been reviewed and renewed by the prescribing Physician at least every thirty (30) calendar days until benefits are exhausted. We reserve the right to request a copy of any written treatment plan in order to determine whether such Services are Covered under this Certificate;
- The Home Health Care Services are provided directly by (or indirectly through) a licensed Home Health Agency; and
- You are meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

Home Health Care Services are limited to:

- A total of sixty (60) visits maximum per Calendar Year as outlined in the Schedule of Benefits;
- Home health aide Services must be consistent with the plan of treatment, ordered by a Physician, and rendered under the supervision of a Registered Nurse;
- Medical social Services;
- Nutritional guidance;
- Respiratory or inhalation therapy (e.g., oxygen);
- PT by a Physical Therapist, OT by an Occupational Therapist, and ST by a Speech Therapist. Therapy provided in the home applies to the Home Health Care Services visit limit instead of therapy limits; and
- Supplies as needed to provide the Covered care to the extent they would have been Covered if under Hospital Confinement.

As needed, the Health Plan will review the Covered Person's Condition and plan of care to assure that the above criteria are continuing to be met and that the Services provided are both skilled and intermittent. Until such time as documentation is provided for review, and in lieu of hospitalization or continued hospitalization, Services will be Covered.

Hospice Services
Health Care Services provided when Hospice Services are the most appropriate and cost-effective treatment in connection with a Hospice treatment program, may be Covered Services, provided the Hospice treatment program is approved by Your Physician. Your Physician may be required to certify Your life expectancy in writing.

To qualify for Coverage, the attending Physician must: (1) certify that the patient is not expected to live more than one (1) year on a life expectancy certification; and (2) submit a written Hospice Care plan or program. Covered Persons who elect Hospice Care under this provision are not entitled to any other Services under this Individual Policy for the terminal illness while the Hospice election is in effect. Under these circumstances, the following Services are Covered:

Home Hospice Care is comprised of:

- Physician Services and part-time or intermittent nursing care by a Registered Nurse or Licensed Practical Nurse;
- Home health aides;
- Inhalation (respiratory) therapy;
- Medical social Services;
- Medical supplies, Drugs, and appliances;
- Medical counseling for the terminally ill Covered Person; and
- PT, OT, and ST as deemed appropriate by the Health Plan.

Inpatient Hospice Care in a Hospice Facility, Hospital, or Skilled Nursing Facility ("SNF"), if approved in writing by the Health Plan, includes care for pain control or acute chronic symptom management.

The Hospice treatment program must:

- Meet the standards outlined by the National Hospice Association;
- Be recognized as an approved Hospice program;
- Be licensed, certified, and registered as required by Florida law; and
- Be directed by a Physician and coordinated by a Registered Nurse, with a treatment plan that provides an organized system of Hospice Facility Care, uses a Hospice team, and has around-the-clock care available.

Health Care Services provided in connection with a Hospice treatment program may be Covered Services, provided the Hospice treatment program is:

- Approved by Your Physician; and

- Your Physician has certified to Us in writing that Your life expectancy is twelve (12) months or less.

Recertification is required every six (6) months.

Hospital Services
The Services and supplies listed below shall be considered Covered Services when provided to a Covered Person at a Hospital on an Inpatient or outpatient basis in accordance with all other plan provisions included herein. The following Services and supplies will be Covered when considered Medically Necessary and may require Prior Authorization. Covered Services are subject to Cost-Share, which may consist of Copayments, Deductibles, and Coinsurance, as noted in the Schedule of Benefits, and include:

- Room and board for semi-private accommodations, unless the Covered Person must be isolated from others for documented clinical reasons;
- Confinement in an intensive care unit, including cardiac, progressive, and neonatal care;
- Covered Physician Services provided while in an Inpatient setting;
- Miscellaneous Hospital Services;
- Drugs and medicines administered by the Hospital;
- Respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
- Rehabilitative Services, when hospitalization is not primarily for rehabilitation;
- Use of operating room and recovery rooms;
- Use of emergency rooms;
- Intravenous solutions;
- Administration and cost of whole blood or blood products (except as outlined in the **Exclusions and Limitations** section);
- Dressings, including ordinary casts, splints, and trusses;
- Anesthetics and their administration;
- Transfusion supplies and equipment;
- Diagnostic Services, including radiology, ultrasound, laboratory, pathology, and approved machine testing (e.g., EKG);
- Imaging Services, including specialty imaging;
- Outpatient observation;
- Chemotherapy treatment for proven malignant disease;
- PT, ST, OT, and Cardiac Therapies;
- Transplants, as described in the Transplant Services category of this section; and
- Other Medically Necessary Services and supplies.

Human Growth Hormone Therapy
Human growth hormone therapy Services are Covered when determined Medically Necessary and authorized in advanced by the Health Plan. Please see the Formulary for Covered products and refer to the **Covered Services** section of this document.

Imaging Services
Covered imaging Services include standard radiology Services and advanced (high-end) imaging, including CT scans, MRIs, Magnetic Resonance Angiography ("MRA"), PET scans, and Nuclear Studies. Advanced imaging requires Prior Authorization.

Immunizations
Immunizations, including flu shots, are Covered when Medically Necessary and not listed as an exclusion. Immunizations recommended by the Centers for Disease Control and Prevention ("CDC") for routine use in adults and children are Covered as Preventive benefits.

Insulin

Insulin Coverage includes the needles and syringes needed for insulin administration. However, the Covered Person must have a Physician's Prescription for such supplies on record with the Pharmacy where the supplies are purchased. Refer to the **Covered Services** section of this document.

Mammograms
Mammograms performed for breast cancer screening or diagnostic testing are Covered. The Health Plan shall provide Coverage for the following:

- A baseline mammogram for any woman who is thirty-five (35) years of age or older, but younger than forty (40) years of age. This is considered a Preventive Health Service, if billed as such, and is not subject to Cost-Share when rendered by a Participating Provider, as set forth in the Schedule of Benefits;
- One (1) mammogram annually for any woman who is forty (40) years of age or older. This is considered a Preventive Health Service, if billed as such, and is not subject to Cost-Share when rendered by a Participating Provider, as set forth in the Schedule of Benefits;
- Additional screening mammograms for any woman who is at risk of breast cancer because of a personal or family history or because of having biopsy-proven benign breast disease, or because a woman has not given birth before the age of thirty (30) (subject to Cost-Share); and
- Diagnostic mammograms for follow-up to a clinical or radiological abnormality (subject to Cost-Share).

Mastectomy Services
Breast cancer treatment, including treatment for physical complications relating to a Mastectomy (including lymphedemas), and outpatient post-surgical follow-up in accordance with prevailing medical standards as determined by the Covered Person and the Covered Person's attending Physician, are Covered when considered Medically Necessary and may require Prior Authorization. Outpatient post-surgical follow-up care for Mastectomy Services shall be Covered when rendered by a Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or the Covered Person's home. The treating Physician, after consultation with the Covered Person, may choose the appropriate setting.

Prophylactic Mastectomy, salpingo-oophorectomy, or hysterectomy to reduce the risk of breast or ovarian cancer is Covered when considered Medically Necessary.

Medical Nutrition Therapy
Medical nutrition therapy for the treatment of cardiovascular and diet-related chronic diseases is Covered as a Preventive benefit. Coverage is limited to three (3) hours per Calendar Year. Covered Services include medical nutrition therapy for the following Conditions: diabetes, heart disease, lipid disorders (e.g., high cholesterol/triglycerides), malnutrition, kidney disease, and obesity.

Mental and Nervous Disorder Treatment
Expenses for the Services and supplies listed below for the treatment of Mental and Nervous Disorders will be considered Covered Services if provided to the Covered Person by a Physician, Psychologist, or Mental Health Professional:

- Inpatient Confinement or Partial Hospitalization in a Hospital or a Psychiatric Facility for the treatment of a Mental and Nervous Disorder if authorized in advance. Partial Hospitalization Services must be provided under the direction of a licensed Participating Physician; and
- Outpatient treatment provided by a licensed psychiatrist, Psychologist, or Mental Health Professional for a Mental and Nervous Disorder, including diagnostic evaluation and psychiatric treatment, individual therapy, and group therapy.

Newborn Care
A Newborn child will be Covered from the moment of birth provided that the Newborn child is eligible for Coverage and properly enrolled. Covered Services shall consist of Coverage for Injury or Sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth.

An assessment of the Newborn child is Covered, provided the Services were rendered at a Hospital, the attending Physician's office, a state licensed and approved Birth Center, or in the home by a Physician, Midwife, or Certified Nurse Midwife, and the performance of any necessary clinical tests and immunizations are within prevailing medical standards. These Services are not subject to the Calendar Year Deductible.

Ambulance Services are Covered when necessary to transport the Newborn child to and from the nearest appropriate Facility which is staffed and equipped to treat the Newborn child's Condition, as determined by Us and certified by the attending Physician as Medically Necessary to protect the health and safety of the Newborn child. The Ambulance Cost-Share set forth in the Schedule of Benefits applies.

Obesity Treatment
Physician counseling and nutritional counseling for obesity management by Network Providers are Covered as Preventive Health Services.

Obstetrical and Maternity Care
Obstetrical and maternity care received on an Inpatient or outpatient basis are Covered, including Medically Necessary prenatal and postnatal care of the mother and baby. Prenatal and postnatal office visits are Covered as a Preventive benefit and are not subject to Cost-Share as set forth in the Schedule of Benefits.

Up to two (2) routine maternity ultrasounds are Covered per pregnancy with associated Cost-Sharing, as well as additional Medically Necessary ultrasounds for high-risk pregnancies. Complications of pregnancy will be treated the same as any other illness.

Services of Certified Nurse Midwives and midwives licensed pursuant to Chapter 467 of the Florida Statutes are Covered in a Facility, including a state licensed and approved Birth Center. Planned home births may be Covered when the delivery is overseen by a Physician, Certified Nurse Midwife, or licensed Midwife and authorized in advance by the Health Plan. Authorization will be considered for low-risk pregnancies that are expected to result in a normal labor and delivery, after examination and evaluation by a licensed Midwife or Obstetrician. An informed consent, signed by the mother, a written plan of action that provides for immediate medical care if an emergency arises, and risk evaluation form must be submitted for Authorization consideration. The Cost-Share for home births will be the same as the Cost-Share for an Inpatient Hospital delivery.

Routine nursery care for the Newborn child during the Covered portion of the mother's Inpatient maternity stay is included under this benefit. For plans that subject an Inpatient maternity stay to Deductible and Coinsurance, the Deductible and Coinsurance will apply to all Allowed charges associated with the Inpatient Hospital stay (with the exception of the routine Newborn assessment and performance of any Newborn clinical tests and immunizations within prevailing medical standards, as described in the Newborn Care category herein).

When the Newborn requires non-routine treatment during or after the mother's Inpatient stay, the Newborn is considered a patient in his or her own right and will be Covered separately only if the Newborn is properly and timely enrolled. In this case, the Newborn's Hospital admission is subject to separate Cost-Share amounts.

Post-delivery care benefits include Coverage for a postpartum assessment and Newborn assessment and may be provided at the Hospital, at the attending Physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. Coverage is provided for a physical assessment of the Newborn and mother, and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards.

Refer to the Obstetrical and Maternity Care category within the **Exclusions and Limitations** section of this Certificate for exclusions related to Services for a Gestational Surrogate.

Orthotic Devices
Orthotic Devices, including braces and trusses for the leg, arm, neck, and back, and special surgical corsets, are Covered when prescribed by a Physician and designed and fitted by an Orthotist. Benefits may be provided for necessary replacement of an Orthotic Device, which is owned by You when due to irreparable damage, wear, a change in Your Condition, or when necessitated due to growth of a child. Payment for splints for the treatment of TMJ dysfunction is limited to one (1) splint in a six-month period, unless a more frequent replacement is determined to be Medically Necessary and authorized in advance by the Health Plan.

Osteoporosis Screening, Diagnosis, and Treatment
Screening, diagnosis, and treatment of osteoporosis for high-risk individuals are Covered, and include:

- Estrogen-deficient individuals who are at clinical risk for osteoporosis;
- Individuals who have vertebral abnormalities;
- Individuals who are receiving long-term glucocorticoid (steroid) therapy;
- Individuals who have primary hyperparathyroidism; and
- Individuals who have a family history of osteoporosis.

Osteoporosis screening for adult women is considered a Preventive Health Service and is not subject to Cost-Share when rendered by a Participating Provider, as set forth in the Schedule of Benefits. Frequency and age limits established by the USPSTF, Florida Statutes or the Health Plan apply.

Outpatient Habilitation Services
The therapies described below are Covered when provided to help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a Covered child who is not walking or talking at the expected age.

- PT provided by a Physician or Licensed Physical Therapist;
- OT provided by a Physician or Licensed Occupational Therapist; and
- ST provided by a Physician or Licensed Speech Therapist.

Coverage for outpatient Habilitation Services is limited to thirty-five (35) visits combined per Calendar Year for each Condition being treated. All therapy Services must be considered Medically Necessary by the Health Plan and may require Authorization in advance. Outpatient Habilitation Services benefit limits do not apply to therapy Services provided for the treatment of a mental health Condition, including Autism Spectrum Disorder, or for the treatment of a SUD.

The outpatient therapies listed in this category are in addition to the therapy benefits listed in the Acute Inpatient Rehabilitation Facility Services, Home Health Care, Hospital Services, Hospice Services, outpatient rehabilitation Services, and SNF Services categories in this section.

Outpatient Rehabilitation Services
The therapies described below are Covered when provided to help a person get back or improve skills and functioning for daily living that have been lost or impaired due to illness, Injury, or disability:

- PT provided by a Physician or Licensed Physical Therapist;
- OT provided by a Physician or Licensed Occupational Therapist;
- ST provided by a Physician or Licensed Speech Therapist;
- Cardiac Rehabilitation Services provided under the supervision of a Physician, or an appropriate Provider trained for cardiac Rehabilitation, for the purpose of aiding in the restoration of optimal heart function in connection with a myocardial infarction, coronary occlusion, or coronary bypass surgery. Coverage is limited to thirty-six (36) sessions per lifetime; and
- Pulmonary Rehabilitation Services provided under the supervision of a Physician, or an appropriate Provider trained for pulmonary Rehabilitation, for the purpose of reducing symptoms, optimizing function, and stabilizing restrictive or obstructive lung disease processes. Coverage is limited to thirty-six (36) sessions per lifetime.

Coverage for outpatient rehabilitation Services is limited to thirty-five (35) visits combined per Calendar Year for each Condition being treated. Coverage for outpatient cardiac and pulmonary Rehabilitation Services is limited to thirty-six (36) sessions per type of therapy, per lifetime. All therapy Services must be considered Medically Necessary by the Health Plan and may require Authorization in advance. Outpatient rehabilitation Services benefit limits do not apply to therapy Services provided for the treatment of a mental health Condition, including Autism Spectrum Disorder, or for the treatment of a SUD.

The outpatient therapies listed in this category are in addition to the therapy benefits listed in the Acute Inpatient Rehabilitation Facility Services, Home Health Care, Hospital Services, Hospice Services, Outpatient Habilitation Services, and SNF Services categories in this section.

Oxygen
Covered oxygen Services include the expenses for oxygen and the rental of the equipment necessary for administration. However, the Health Plan reserves the right to monitor a Covered Person's use of oxygen to assure its safe and for medically appropriate use. Reimbursement is based on Medicare guidelines, which cap rental payments at thirty-six (36) months, allowing payment for contents and supplies afterwards. If Your oxygen equipment is still Medically Necessary after thirty-six (36) months, Your supplier must continue to maintain the oxygen equipment (in good working order) and furnish the equipment and any necessary supplies and accessories, for up to an additional twenty-four (24) months. New rental equipment may be obtained after five (5) years. A new 36-month payment period and five (5) year supplier obligation period starts once the old five (5) year period ends for Your new oxygen and oxygen equipment.

Pain Management
Pain Management Services that are determined to be Medically Necessary are Covered and may require Prior Authorization.

Palliative Care
Palliative Care that is determined to be Medically Necessary is Covered and may require Prior Authorization.

Pap Smears
Pap smears are Covered as a Preventive Health Service when performed as recommended by the USPSTF or in accordance with Health Resources and Services Administration ("HRSA") supported Women's Preventive Services Guidelines. Additional pap smears are Covered as diagnostic laboratory tests when Medically Necessary.

Pathologist Services

Pathologist Services that are provided on an Inpatient or outpatient basis are Covered. These professional Services are not Covered when associated with automated clinical lab tests that do not require interpretation by the pathologist.

Pediatric Dental Services
The following pediatric dental Services are Covered up through the end of the birth month in which the Covered Person reaches age nineteen (19) when provided by a Participating Provider:

- One (1) dental check-up visit per six (6) months;
- Basic dental care;
- Major dental care; and
- Medically Necessary Orthodontic Services.

Pediatric dental Services are Covered when they are Medically Necessary and within the standards of generally accepted dental practice. Please see the **Pediatric Dental Benefits** section of this Certificate for additional Coverage information and requirements.

Pediatric Vision Services
The following pediatric vision Services are Covered up through the end of the birth month in which the Covered Person reaches age nineteen (19) when provided by a Participating Provider:

- One (1) routine vision exam per Calendar Year (includes dilation, if professionally indicated, and contact lens fitting for Covered Persons who wear contact lenses); and
- One (1) pair of standard child frame and basic lenses per Calendar Year. Eligible prescription lenses include single vision, bifocal, trifocal, or lenticular lenses; or
- Up to two (2) prescription fills of standard contact lenses, in lieu of eyeglasses, once per Calendar Year.

Pediatric vision Services or materials that are not furnished by a Participating ophthalmologist, optometrist, or optician are not Covered.

The above Covered Services are separate from the vision benefit described in the Vision Services category.

The Health Plan contracts with a third party vision Provider to offer pediatric vision Services, classified as essential health benefits, for any Covered Person who meets and continues to meet the eligibility requirements specified in this Certificate. To view plan details, visit www.davisvision.com or contact the vision Customer Service Center at 1.800.999.5431.

Physician Services
Covered Services include Medically Necessary medical or surgery Services provided in a Physician's office or in an outpatient Facility, such as office visits, testing, treatment, and surgical Health Care Services provided by a Physician. Physician Services are excluded from Coverage when provided by a person who is related to You by blood, marriage, Adoption, or Domestic Partnership. Self-care is also excluded from Coverage.

Practitioner-Administered Medications
Medications administered by a Health Care Provider in an office or outpatient setting are Covered. Covered Services include chemotherapy, Drug infusions, therapeutic injections, allergy immunotherapy, and other medications ordered and administered by a Provider. Prior Authorization may be required by the Health Plan. Medications that require approval in advance are specifically noted in the Health Plan's Authorization List as being subject to Prior Authorization.

Practitioner-administered medications are subject to the Cost-Share set forth in the Schedule of Benefits attached to this Certificate and will apply to unused/discarded units of the medical Drug.

Pre-Admission Tests
Pre-admissions tests are Covered when ordered or authorized by a Participating Physician. However, the following conditions must be met:

- The tests must be performed within seven (7) days before admission to the Hospital or the Outpatient Surgery center;
- The tests are performed in a Facility accepted by the Hospital in place of the same tests that would normally be done while Hospital confined; and
- The Covered Person is subsequently admitted to the Hospital or the Outpatient Surgery is performed, except if a Hospital bed is unavailable or because there is a change in the Covered Person's Condition that would preclude performing the procedure.

Prepared Childbirth Classes
Prepared childbirth classes such as birthing classes, Lamaze classes, childbirth refresher classes, or cesarean birth classes, are Covered up to seventy-five dollars ($75) per Calendar Year, per Covered Person.

Prescription Drugs (Outpatient)
Outpatient Prescription Drugs included in the Formulary are Covered. All other plan requirements, including Medical Necessity, Prior Authorization, and step therapy must also be met for the Prescription Drugs to be a Covered benefit.

Preventive Child Medical Services (Child Health Supervision Services)
Periodic Physician-delivered or Physician-supervised Services from the moment of birth up to the nineteenth (19th) birthday, are Covered as follows:

- Periodic examinations, which include a history, a physical examination, and a developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child;
- Oral and/or injectable immunizations; and
- Laboratory tests normally performed for a well-child.

In order to be Covered, Services shall be provided in accordance with prevailing medical standards consistent with the recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics, the USPSTF, or the Advisory Committee on Immunization Practices established under the Public Health Service Act.

Note: This benefit is considered a Preventive Health Service if billed as such and may not be subject to Cost-Share when rendered by a Participating Provider, as set forth in the Schedule of Benefits.

Preventive Medical and Gynecological Services
The following Preventive Health Services are Covered without Cost-Share when obtained from Participating Providers according to current guidelines:

- Services recommended by the USPSTF with a current rating of "A" or "B";
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC for routine use in children, adolescents, and adults;
- Preventive care and screenings for infants, children, and adolescents that are provided for in the comprehensive guidelines supported by the HRSA; and
- Preventive care and screenings for women that are provided for in comprehensive guidelines supported by the HRSA.

A routine physical exam for adults and a routine gynecological exam for women are also Covered as Preventive benefits once per Calendar Year, to include the evaluation and management of the patient with an age and gender-appropriate history, examination, and counseling, as well as

ordering of laboratory or other diagnostic tests. Only those tests given an "A" or "B" rating by the USPSTF will be Covered as Preventive Health Services.

This benefit does not include exams required for travel, or those needed for school, employment, insurance, or governmental licensing, or when required by law enforcement, unless the Service is within the scope of, and coinciding with, the annual physical exam.

The Health Plan may offer a voluntary wellness or health improvement program and may encourage or reward participation in the program by authorizing rewards or incentives, including, merchandise, gift cards, debit cards, Premium discounts, contributions to an Insured's Health Savings Account ("HSA"), or modifications to Copayment, Deductible, or Coinsurance amounts.

Prosthetic Devices (External)
The following Prosthetic Devices are Covered when considered Medically Necessary and authorized in advance by the Health Plan, prescribed by a Physician, and designed and fitted by a Prosthetist. Instruction and appropriate Services required for the Covered Person to properly use the item (such as attachment or insertion) are Covered. The Health Plan reserves the right to provide the most cost efficient and least restrictive level of Service or item that can safely and effectively be provided. Covered devices include:

- Artificial hands, arms, feet, legs, and eyes, including permanent implanted lenses following cataract surgery, cardiac pacemakers, and Prosthetic Devices incident to a Mastectomy;
- Appliances needed to effectively use artificial limbs or corrective braces;
- Penile prosthesis; and
- Wigs or cranial prosthesis when related to restoration after cancer or brain tumor treatment.

Covered Prosthetic Devices (except cardiac pacemakers and Prosthetic Devices incident to Mastectomy) are limited to the first permanent prosthesis (including the first temporary prosthesis if it is determined to be necessary) prescribed for each specific Condition.

Benefits may be provided for necessary replacement of a Prosthetic Device which is owned by You when due to irreparable damage, wear, or a change in Your Condition, or when necessitated due to growth of a child.

Radiologist Services
Radiologist Services are Covered on an Inpatient or outpatient basis.

Second Medical Opinions
Each Covered Person is entitled to request a second medical opinion by a Physician of his or her choice subject to the following conditions:

- The Covered Person disagrees with a Physician's opinion regarding the reasonableness or necessity of a surgical procedure, or the treatment is for a serious Injury or illness;
- Second opinions by Non-Participating Physicians must be authorized by the Health Plan in advance. If further diagnostic tests are required, the Health Plan reserves the right to require such testing to be performed In-Network. Out-of-Network Services of any kind must be authorized by the Health Plan in advance;
- The Covered Person will pay applicable Cost-Sharing amounts for a second opinion by a Participating Physician;
- The Health Plan will pay sixty percent (60%) of the Allowed Amount for a second opinion by a Non-Participating Physician;
- Only one (1) second opinion is Covered for the Condition being evaluated, unless the first two (2) opinions substantially disagree. If the opinions disagree, a third opinion will be Covered according to the provisions contained in this section;

- A maximum of three (3) opinions may be Covered for any one (1) Condition in a Calendar Year. Additional opinions may be authorized at the sole discretion of the Health Plan;
- The Covered Person's Physician and the Health Plan's Medical Director's judgment concerning the treatment shall be controlling, after review of the second opinion, as to the obligations of the Health Plan; and
- Any treatment, including follow-up treatment pursuant to the second opinion must be authorized by the Health Plan if Prior Authorization is required for the Service.

Self-Administered Prescriptions Drugs
Coverage of self-administered Prescription Drugs applies to those used in the treatment of diabetes, cancer, Conditions requiring immediate stabilization (e.g., anaphylaxis), those used in the administration of dialysis, or as otherwise listed in the Formulary.

Sexual Reassignment or Modification Services
Sexual reassignment and modification Services are Covered when considered Medically Necessary and authorized in advance by the Health Plan.

Skilled Nursing Facility ("SNF") Services
SNF Services are Covered only if a written plan of treatment is submitted by a Physician and only if the Health Plan agrees that such skilled level Services are being provided in lieu of hospitalization or continued hospitalization. The number of days Covered are limited to sixty (60) days per Calendar Year as outlined in the Schedule of Benefits. When authorized in advance, the following Health Care Services may be Covered Services when You are an Inpatient in a SNF:

- Room and board;
- Respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
- Drugs and medicines administered while Inpatient (except take-home Drugs);
- Intravenous solutions;
- Administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the **Exclusions and Limitations** section);
- Dressings, including ordinary casts;
- Transfusion supplies, and equipment;
- Diagnostic Services, including radiology, ultrasound, laboratory, pathology, and approved machine testing (e.g., EKG);
- Chemotherapy treatment for proven malignant disease;
- Physical, Speech, and Occupational Therapies; and
- Other Medically Necessary Services and supplies.

If a Covered Person is a resident of a continuing care Facility certified under Florida Statutes or a retirement Facility consisting of a nursing home or assisted living Facility, the Covered Person's PCP must refer the Covered Person to that Facility's skilled nursing unit or assisted living Facility if:

- Requested by the Covered Person and agreed to by the Facility;
- The PCP finds that such care is Medically Necessary;
- The Facility agrees to be reimbursed at the Health Plan's contracted rate negotiated with similar Providers for the same Services and supplies; and
- The Facility meets all guidelines established by the Health Plan related to quality of care, utilization, referral, Authorization, and other criteria applicable to Providers under contract for the same Services.

If the Health Plan enrolls a new Covered Person who already resides in a continuing care Facility or retirement Facility as described herein, and that Covered Person's request to reside in a skilled nursing unit or assisted living Facility is denied, the Covered Person may use the Grievance

Process outlined in the **Complaint, Grievance, and Appeal Procedures** section of this Certificate.

Skin Substitutes
Skin Substitutes that are determined to be Medically Necessary are Covered and may require Prior Authorization.

Sleep-Related Disorders Testing and Treatment
Sleep-related disorder testing and treatment, including sleep studies, Positive Airway Pressure devices, and sleeping agents listed in the Formulary, is Covered when Medically Necessary and authorized in advance by the Health Plan when required.

Smoking and Tobacco Use Cessation Services and Treatment
Smoking and tobacco use cessation counseling is Covered as a Preventive Health Service in accordance with current USPSTF recommendations.

Tobacco cessation medications and products prescribed by a Health Care Provider and listed on the Formulary are Covered under the Prescription Drug benefit.

Spine and Back Disorder Chiropractic Treatment
Services rendered by Physicians for manipulations of the spine to correct a slight dislocation of a bone or joint that is demonstrated by x-ray, are Covered when considered Medically Necessary and authorized in advance by the Health Plan, when required.

Payment guidelines for spinal manipulation are as follows:

- Payment for Covered spinal manipulation is limited to no more than twenty-six (26) spinal manipulations per Calendar Year.

Surgical Assistant Services
Services are Covered when rendered by a Physician, Registered Nurse First Assistant, or Physician Assistant when acting as a surgical assistant (provided no intern, resident, or other staff Physician is available) when such assistance is Medically Necessary.

Surgical Procedures
Surgical procedures that are Medically Necessary, authorized in advance by the Health Plan when required, and performed by a Physician on an Inpatient or outpatient basis may be Covered, and include the following:

- Sterilization (tubal ligations and vasectomies), regardless of Medical Necessity. Sterilization Services for women are Covered as a Preventive benefit. Vasectomies for men are subject to Cost-Sharing;
- Surgery to correct deformity that was caused by disease, trauma, birth defects, growth defects, or prior therapeutic processes;
- Oral surgical procedures for excisions of tumors, cysts, abscesses, and lesions of the mouth;
- Surgical procedures involving bones or joints of the jaw (e.g., TMJ) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or Injury; and
- Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic Services to help determine the need for surgery.

Payment guidelines for surgical procedures are as follows:

- In accordance with CMS coding guidelines, payment for multiple surgical procedures performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on fifty percent (50%) of the Allowed Amount for any secondary surgical procedure(s) performed and is subject to the Cost-Share

amount (if any) indicated in Your Schedule of Benefits. This guideline is applicable to all bilateral procedures and some surgical procedures performed on the same date of Service;

- Payment for incidental surgical procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An "incidental surgical procedure" includes surgery where one (1) or more surgical procedures is performed through the same incision or operative approach as the primary surgical procedure which, in Our opinion, is not clearly identified and/or does not add significant time or complexity to the surgical session. For example, the removal of a normal appendix performed in conjunction with a Medically Necessary hysterectomy is an incidental surgical procedure (i.e., there is no payment for the removal of the normal appendix in the example); and
- Payment for surgical procedures for fracture care, dislocation treatment, debridement, wound repair, Unna boot (compression dressing), and other related Health Care Services, is included in the Allowed Amount for the surgical procedure.

Telehealth
Telehealth is available for mental health office visits, PCP, Specialist, and Urgent Care Services. If You choose to access one of these Services by Telehealth, You must use an In-Network Provider who offers the Service by Telehealth. Please contact the Health Plan for a listing of In-Network Telehealth Providers.

Transplant Services
Transplant Services, limited to the procedures listed below, may be Covered when authorized in advance, performed at a Facility acceptable to the Health Plan, and are subject to the conditions and limitations described below.

Transplant includes pre-Transplant, Transplant and post-discharge Services, and treatment of complications after transplantation. We will pay benefits only for Services, care, and treatment received or provided in connection with the approved transplantation of the following human tissue or organs:

- Cornea;
- Heart;
- Liver;
- Kidney;
- Lung - whole single or whole bilateral Transplant;
- Pancreas;
- Multi Organ (as Medically Necessary); and
- Bone Marrow Transplant, as defined in the **Definitions** section of this Certificate, when determined to be accepted within the appropriate oncological specialty and not experimental pursuant to Florida Statutes. The Health Plan will Cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be Covered for the Covered Person and will be subject to the same limitations and exclusions as would be applicable to the Covered Person. Coverage for the reasonable expenses of searching for the donor will be limited to a search among immediate family members and donors identified though the National Bone Marrow Donor Program.

The Health Plan may Cover artificial heart devices when Medically Necessary and authorized in advance by the Health Plan.

This Transplant benefit is subject to Prior Authorization requirements, and as such, the Covered Person or the Covered Person's Physician must notify the Health Plan in advance of the Covered Person's initial evaluation for the procedure in order for the Health Plan to determine if the Transplant Services will be Covered. For approval of the Transplant itself, the Health Plan must be given the opportunity to evaluate the clinical results of the evaluation. Such evaluation and approval will be

based on written criteria. If approval is not obtained, benefits will not be provided for the Transplant procedure.

Once the Transplant procedure is approved, the Health Plan will advise the Covered Person's Physician of those Facilities that have been approved for the type of Transplant procedure involved. Benefits are payable only if the pre-Transplant Services, the Transplant procedure, and post-discharge Services are performed in an approved Facility.

For approved Transplant procedures, and all related complications, the Health Plan will pay benefits only for the following Covered expenses:

- Hospital expenses and Physician's expenses will be paid under the Hospital Services benefit and Physician Services benefit in this Individual Policy in accordance with the same terms and conditions, as the Health Plan will pay benefits for care and treatment of any other Covered Condition; and
- Organ acquisition, donor costs, and Bone Marrow Transplants as specifically outlined in this Certificate. However, donor costs are not payable under this Individual Policy if they are payable in whole or in part by any other insurance health plan, organization, or person other than the donor's family or estate.

In addition to the Services above, reasonable and necessary travel and lodging expenses directly related to a Covered solid organ and/or blood and marrow Transplant are reimbursable when the Transplant is pre-authorized by the Health Plan as an In-Network Transplant.

Transportation to and from the approved Transplant Facility for the Transplant procedure is Covered. In the event the Covered Person's required pre-Transplant evaluation at the approved Facility extends beyond one (1) day, transportation to and from the Facility for the evaluation is also Covered. Travel expenses are reimbursable, according to the following terms and limitations:

- For travel by personal vehicle, local mileage to and from the approved Transplant Facility is reimbursable at the current Internal Revenue Service ("IRS") allowable rate. Expenses for tolls are reimbursable, when applicable. Mileage will be calculated as the distance from the Covered Person's street address of record to the street address of the approved Transplant Facility;
- Commercial round trip coach airfare, bus, or train transportation to and from the city where the approved Transplant Facility is located is Covered for the Covered Person and one (1) companion (up to two (2) companions if the Covered Person is under the age of eighteen (18) years);
- The cost of lodging for the Covered Person (while not hospitalized) and one (1) companion (up to two (2) companions if the Covered Person is under the age of eighteen (18) years) is Covered during the Covered Person's episode of care, not to exceed one hundred and twenty-five dollars ($125), per day in total reimbursement; and
- The daily maximum will not be multiplied by the number of Covered days to establish the maximum amount payable for the episode of care (i.e., each Covered day will be considered independently for reimbursement). This reimbursement is only applicable to the cost of the room and taxes during the Covered Person's episode of care.

Travel and lodging expenses, as described above, are subject to a maximum Allowance of ten thousand dollars ($10,000) per Transplant. To be reimbursed for Covered expenses, the Covered Person must submit a Claim for plan benefits, along with legible itemized bills/statements and paid receipts, in accordance with the procedure and timeline outlined in the **Claim Provisions** section of this Certificate.

Items and Services excluded from Coverage include: meals/food, beverages, entertainment (e.g., movie rentals, books, magazines, etc.), security deposits, convenience items, phone calls, room service, mileage within the city where the Transplant Facility is located, frequent flyer miles, childcare Services, kennel fees, and gas.

Vision Services
Coverage includes the following Services:

- Physician Services, soft lenses, or sclera shells for the treatment of aphakic patients;
- Initial glasses or contact lenses following cataract surgery;
- Physician Services to treat an Injury to or disease of the eyes; and
- One (1) diabetic retinopathy screening is Covered per Calendar Year, subject to the Specialist Cost-Share set forth in the Schedule of Benefits.

The above Covered Services are separate from the Pediatric Vision Benefit described in the Pediatric Vision Services category.

Walk-In Clinic Visits
Covered expenses include charges made by Walk-In Clinics for:

- Unscheduled, non-emergency illnesses and Injuries;
- The administration of certain immunizations administered within the scope of the clinic's license; and
- Covered individual screening and counseling Services administered within the scope of the clinic's license.

Well Woman Annual Exam
An annual well woman gynecological exam is Covered at an OB/GYN or PCP's office. This benefit is considered a Preventive Health Service if billed as such and may not be subject to Cost-Share when rendered by a Participating Provider as set forth in the Schedule of Benefits.

V. EXCLUSIONS & LIMITATIONS

A. ACCESS RULES

If a Covered Person did not follow the access rules described in this section, the Covered Person risks having Services and supplies received not Covered by this Individual Policy. In such a circumstance, the Covered Person would be responsible for the entire cost of the Services rendered.

Services that are provided or received without having been prescribed, directed, or authorized in advance by the Health Plan when required, are not Covered. Except for Emergency Services and Care for an Emergency Medical Condition or Out-Of-Area Urgent Care, all Services and supplies must be received from Participating Providers.

Services that, in the Health Plan's opinion, are not Medically Necessary will not be Covered. The ordering of a Service by a Physician, whether participating or Non-Participating, does not in itself make such Service Medically Necessary or a Covered Service. Whether a Service is a Covered Service is determined according to the terms of the Individual Policy as solely interpreted by the Health Plan or its delegate.

B. HEALTH CARE SERVICES EXCLUSIONS

In addition to the access rule conditions noted above, the Services and supplies listed in this section are excluded from Coverage and are not Covered Services and supplies under this Individual Policy.

Abortion
Abortion, including any Service or supply related to an elective abortion, is excluded from Coverage. However, spontaneous abortions are not excluded nor are abortions performed when the life of the

mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

Alcohol or Drug-Related Injuries
Alcohol or Drug-related Injuries or disabilities, when sustained as a result of being addicted to alcohol or drugs, or under the influence of alcohol, an intoxicant, an illegal substance, or a narcotic unless administered by a Physician and taken according to the Physician's instructions, are excluded from Coverage.

Alternative Medical Treatments
Alternative medical treatments, which include the following, are excluded from Coverage:

- Self-care or self-help training;
- Homeopathic medicine and counseling;
- Ayurvedic medicine, such as lifestyle modifications and purification therapies;
- Traditional Oriental medicine, including acupuncture;
- Massage therapy;
- Naturopathic medicine;
- Environmental medicine, including the field of clinical ecology;
- Chelation therapy;
- Thermography;
- Mind-body interactions, such as meditation, imagery, yoga, dance, and art therapy;
- Biofeedback Services, except when considered Medically Necessary by the Health Plan and authorized in advance;
- Prayer and mental healing;
- Manual healing methods, such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, the Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics;
- Reiki, SHEN therapy, and therapeutic touch;
- Bioelectromagnetic applications in medicine; and
- Herbal therapies.

Ambulance Services Provided Without Transfer
Ambulance Services provided without transfer to a Facility are not Covered.

Anesthesia Administration Services
Anesthesia Services by an operating Physician or his or her partner or associate are not Covered. Refer to the **Covered Services** section of this Certificate for Covered anesthesia administration Services.

Applied Behavior Analysis ("ABA") Services
ABA Services, except those used in the treatment of Autism Spectrum Disorder or Down syndrome as set forth in the **Covered Services** section, are excluded from Coverage.

Arch Supports
Shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, OTC, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances, regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) when Medically Necessary, are excluded from Coverage.

Assisted Reproductive Therapy (Infertility)
Assisted reproductive therapy, including associated Services, supplies, and medications for In Vitro Fertilization ("IVF"), Gamete Intrafallopian Transfer ("GIFT") procedures, Zygote Intrafallopian

Transfer ("ZIFT") procedures, Artificial Insemination ("AI"), embryo transport, surrogate parenting, donor semen and related costs, including collection and preparation, and Infertility treatment medication, are excluded from Coverage.

Autopsy or Postmortem Examination Services
Autopsy or postmortem examination Services are excluded from Coverage, unless specifically requested by the Health Plan.

Blood Fees
Blood fees associated with the collection, storage, or donation of blood or blood products are excluded from Coverage, except for autologous donation in anticipation of scheduled Services where, in the Health Plan's opinion, the likelihood of excess blood loss is such that transfusion is expected supplementary to surgery.

Bloodless Surgery
Bloodless Surgery is excluded from Coverage, unless comparable outcomes, complication rates, and mortality rates are demonstrated through peer reviewed clinical studies when compared to standard surgical methods.

Breast Reduction Services
Breast reduction Services are excluded from Coverage, unless determined to be Medically Necessary and authorized in advance by the Health Plan. Reduction mammoplasty for asymptomatic Covered Persons is considered cosmetic and is excluded from Coverage. Reduction mammoplasty may be considered Medically Necessary when the Covered Person's Condition is such that it causes significant clinical manifestations.

Charges, Expenses, or Costs Applied Toward Satisfaction of any Applicable Deductible, Coinsurance, or Copayment Amounts
Such charges, expenses, or costs are the Covered Person's responsibility and are not Covered by the Health Plan.

Charges, Expenses, or Costs in Excess of the Allowed Amount
Charges, expenses, or costs in excess of the Health Plan's Allowed Amount for Covered Services are excluded from Coverage.

Charges Incurred Outside of the United States
Charges incurred outside of the United States are excluded from Coverage if the Covered Person traveled to such location to obtain medical Services, Drugs, or supplies, or when such Services, Drugs, or supplies are illegal in the United States.

Complications of Non-Covered Services
Complications of non-Covered Services, including the diagnosis or treatment of any Condition which arises as a complication of a non-Covered Service (e.g., Health Care Services to treat a complication of Cosmetic Surgery) are not Covered.

Cosmetic Surgery
Plastic and Reconstructive Surgery and other Services and supplies to improve the Covered Person's appearance or self-perception (except as Covered under the Breast Cancer Treatment category in the **Covered Services** section of this Certificate), including, without limitation, procedures or supplies to correct hair loss or the appearance of skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/Transplants, are excluded from Coverage.

Costs Incurred
Costs Incurred by the Covered Person related to the following, are excluded from Coverage:

- Health Care Services resulting from Accidental bodily Injuries arising out of a motor vehicle Accident to the extent such Services are payable under any medical expense provision of any automobile insurance policy or liability policy; and
- Failure to keep a scheduled appointment, or completion of any form and/or medical information.

Custodial Care
Custodial Care, including any Service or supply of a custodial nature primarily intended to assist the Covered Person in the activities of daily living, is excluded from Coverage. This exclusion includes rest homes, home health aides (sitters), home parents, domestic maid services, Respite Care, and provision of Services which are for the sole purpose of allowing a family member or caregiver of a Covered Person to return to work.

Dental Services
All dental procedures, other than those described in the **Covered Services** section of this Certificate, are excluded from Coverage. This exclusion includes the following: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment, including palatal expansion devices, bruxism appliances, and dental x-rays. Dental Services related to the treatment of malocclusion or malposition of the teeth or jaws (orthognathic treatment), as well as TMJ syndrome or craniomandibular jaw disorders ("CMJ"), are also excluded. Non-dental treatments for these Conditions may be Covered if deemed Medically Necessary and authorized in advance by the Health Plan. Additionally, dental Services provided more than sixty-two (62) days after the date of an Accidental Dental Injury, regardless of whether the Services could have been rendered within sixty-two (62) days, are excluded from Coverage.

Medications used to treat excluded dental Conditions (periodontitis and/or periodontal disease) are excluded from Prescription Drug Coverage unless listed on the Formulary.

This exclusion does not apply to dental Services Covered under the Dental Services, Cleft Lip and Cleft Palate Treatment, and pediatric dental Services categories of the **Covered Services** section of this Certificate.

Diagnostic Services
Laboratory testing for surveillance or public health purposes is excluded from Coverage. Examples include: screening for general workplace/school health and safety ("return-to-work" or "return-to-school"), for public health surveillance, travel-related, or for any other purpose not primarily intended for individualized diagnosis or treatment.

Durable Medical Equipment ("DME")
DME items that are primarily for convenience and/or comfort; items available OTC; wheelchair lifts or ramps; modifications to motor vehicles and/or homes, such as wheelchair lifts or ramps; water therapy devices, such as Jacuzzis, swimming pools, whirlpools, or hot tubs; exercise and massage equipment; air conditioners and purifiers; humidifiers; water softeners and/or purifiers; pillows, mattresses, or waterbeds; escalators; elevators; stair glides; emergency alert equipment; handrails and grab bars; heat appliances; dehumidifiers; and the replacement of equipment, unless it is non-functional and not practically repairable, are excluded from Coverage.

Refer to the **Covered Services** section of this Certificate for Covered DME items.

Experimental and Investigational Treatment
Experimental and Investigational Treatment, as defined in the **Definitions** section of this Certificate, are excluded from Coverage. This exclusion does not include routine costs that would otherwise be Covered if the Covered Person were not enrolled in a clinical trial, as well as Services except as

otherwise Covered under the Bone Marrow Transplant provision of the Transplant Services category, both described in the **Covered Services** section of this Certificate.

Failure to Follow Treatment
Further care for a Condition under treatment will not be Covered if the Covered Person refuses to accept any treatment, procedure, or Facility transfer recommended by the Health Plan.

Food and Food Products
Food and food products, including oral nutrition supplements, are excluded from Coverage with the exception of those listed as Covered Services under the Enteral/Parenteral and Oral Nutrition Therapy category of the **Covered Services** section of this Certificate.

Hearing Aids
Hearing aids (external or implantable) and Services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries, and cost of repair, are excluded from Coverage. Refer to the **Covered Services** section of this Certificate for information on Covered Hearing Devices.

Hearing Services
Routine hearing exams and screenings are excluded from Coverage. This exclusion does not include routine hearing screenings for Newborns, children, and adolescents, which are Covered as a Preventive Health Service in accordance with recommendations from the HRSA's Bright Futures Project.

Home Health Care Services
The following Home Health Care Services are excluded from Coverage:

- Homemaker or domestic maid Services;
- Sitter or companion Services;
- Services rendered by an employee or operator of an adult congregate living Facility, an adult foster home, an adult day care center, or a nursing home Facility;
- Custodial Care;
- Food, housing, and home delivered meals; and
- Services rendered in a Hospital, nursing home, or intermediate care Facility.

If the Covered Person's Condition does not warrant the Services being provided, or if the Services are custodial in nature, the Services will be denied. Any Services that would not have been Covered had the Covered Person been confined in a Hospital are also excluded from Coverage. Refer to the **Covered Services** section of this Certificate for information on Covered Home Health Care Services.

Hospice Services
Covered Hospice Services do not include bereavement counseling, pastoral counseling, financial or legal counseling, or Custodial Care. Refer to the Hospice Services category in the **Covered Services** section of this Certificate for information on Covered Hospice Services.

Hospital Services
The following Hospital Services are excluded when such Services could have been provided without admitting the Covered Person to the Hospital:

- Room and board provided during the admission;
- Physician visits provided while the Covered Person was an Inpatient;
- OT, ST, PT, and Cardiac Therapy; and
- Other Services provided while the Covered Person was an Inpatient.

In addition, expenses for the following and similar items are also excluded:

- Gowns and slippers;
- Shampoo, toothpaste, body lotions, and hygiene packets;

- Take-home Drugs;
- Telephone and television;
- Guest meals or gourmet menus; and
- Admissions kits.

Refer to the **Covered Services** section of this Certificate for information on Covered Hospital Services.

Hypnotism or Hypnotic Anesthesia
Hypnotism and hypnotic anesthesia are excluded from Coverage.

Immunizations and Physical Examinations
Immunization and physical examinations, when required for travel or when needed for school, employment, insurance, or governmental licensing, are excluded from Coverage, except as such examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements.

Infertility Treatment
Infertility treatment Services and supplies, including Infertility testing, treatment of Infertility and diagnostic procedures to determine or correct the cause or reason for Infertility, or inability to achieve conception, are excluded from Coverage. This exclusion includes medications such as clomiphene citrate ("Clomid"), AI, IVF, ovum or embryo placement or transfer, GIFT, cryogenic, or other preservation techniques used in such or similar procedures.

Injectables
Any injection medication that is not self-administered (i.e., IV administration, Medical Professional administration only, etc.) is excluded from Prescription Drug Coverage unless otherwise noted in the Formulary or approved in advance by the Health Plan.

Learning and Developmental Services
Testing, therapy, or treatment for reading and learning disabilities are not Covered. Services or treatment for intellectual disability or other mental Services are not Covered unless determined to be Medically Necessary.

Massage Therapy
Massage therapy is excluded from Coverage.

Mental Health Services and Supplies
The following mental health Services are excluded from Coverage:

- Services rendered in connection with a Condition not classified in current versions of standard code sets, including the International Classification of Diseases, Clinical Modification ("ICD-CM") or the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause or effect of the disorder;
- Services extended beyond the period necessary for evaluation and diagnosis of learning disabilities or for intellectual disability;
- Services for marriage and juvenile counseling, when not rendered in connection with a Condition classified in current versions of standard code sets, including the ICD-CM or the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause or effect of the disorder;
- Services for pre-marital counseling;
- Services for court-ordered care or testing, or required as a condition of parole or probation;
- Services for testing for aptitude, ability, intelligence, or interest;

- Services for testing and evaluation for the purpose of maintaining employment;
- Services for cognitive remediation; and
- Inpatient Confinements that are primarily intended as a change of environment.

Refer to the **Covered Services** section of this Certificate for information on Covered Mental and Nervous Disorder Treatment.

Military Facility Services
Services that are eligible for Coverage by the United States government, as well as any military service-connected care for which the Covered Person is legally entitled to receive from military or government Facilities when such Facilities are reasonably accessible to the Covered Person, are excluded from Coverage.

Missed Appointment Charges
Charges incurred by the Covered Person as a result of missed appointments are excluded from Coverage.

Non-Medically Necessary Services
Non-Medically Necessary Services are excluded from Coverage, and include those Services and supplies:

- Which are not Medically Necessary, as determined by the Health Plan, for the diagnosis and treatment of illness, Injury, or restoration of physiological functions;
- That do not require the technical skills of a medical, mental health, or a dental professional;
- Furnished mainly for the personal comfort or convenience of the Covered Person, or any person who cares for the Covered Person, or any person who is part of the Covered Person's family, or any Provider;
- Furnished solely because the Covered Person is an Inpatient on any day in which the Covered Person's disease or Injury could safely and adequately be diagnosed or treated while not confined; and
- Furnished solely because of the setting if the Service or supply could safely and adequately be provided in a Physician's or a Dentist's office or other less costly setting.

Non-Participating Provider Services
Services and supplies rendered or provided by Non-Participating Providers are excluded from Coverage, unless authorized in advance by the Health Plan or for Emergency Services or Out-Of-Area Urgent Care.

Non-Prescription Drugs
Non-Prescription Drugs, including any vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods, which are not included in the Formulary, are excluded from Coverage.

Nutritional Foods
Nutritional foods, except as listed in the **Covered Services** section of this Certificate, are excluded from Coverage.

Obesity Procedures
Bariatric Surgery and medical procedures for the treatment of morbid obesity are excluded from Coverage. This exclusion does not include Services described in the Obesity Treatment category of the **Covered Services** section of this Certificate.

Obstetrical and Maternity Care
Maternity Services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate, are excluded from Coverage. This exclusion applies to all expenses for prenatal, Intrapartum (care provided during delivery and childbirth), and postpartum (care provided to the

mother following delivery and childbirth) maternity/obstetrical care rendered to the Covered Person acting as a Gestational Surrogate.

Occupational Injury and Work-Related Condition Services
Expenses in connection with any Condition for which a Covered Person has received, or is expecting to receive (whether by settlement or by adjudication), any benefit under Workers' Compensation, Occupational Disease Law, or similar law, are excluded from Coverage. Services that would otherwise be eligible for coverage by Workers' Compensation insurance but were not claimed, are also excluded from Coverage. If the Covered Person enters into a settlement giving up rights to recover past or future medical benefits, this Individual Policy will not Cover past or future medical Services that are subject of or related to that settlement. In addition, if the Covered Person is covered by a Workers' Compensation program that limits benefits if other than specified Health Care Providers are used, and the Covered Person receives care or Services from a Health Care Provider not specified by the program, the Health Plan will not Cover the balance of any costs remaining after the program has paid.

Oral Surgery
Oral surgery is excluded from Coverage, except as provided under the **Covered Services** section of this Certificate.

Organ Donor Treatment and Services
Organ donor treatment and Services, when the Covered Person acts as the donor, are excluded from Coverage. Organ screening and testing for possible match/compatibility are not Covered, except as specifically Covered for bone marrow donors as described in the **Covered Services** section of this Certificate.

Orthomolecular Therapy
Orthomolecular therapy, including nutrients, vitamins, and food supplements, is excluded from Coverage.

Orthotic Devices
The following expenses are excluded from Coverage:

- Expenses for arch supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, heel inserts, OTC, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances, regardless of intended use, except for therapeutic shoes (including inserts and/or modification) when medically necessary, or foot infections;
- Expenses for orthotic appliances or devices which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding (e.g., dynamic orthotic cranioplasty or molding helmets), except when the orthotic appliance or device is used as an alternative to an internal fixation device as a result of surgery for craniosynostosis; and
- Expenses for devices necessary to exercise, train, or participate in sports (e.g., custom-made knee braces).

Over-the-Counter ("OTC") Items
Supplies obtained without a Prescription are excluded from Coverage. Examples of these supplies include ace bandages, elastic stockings, gauze, and dressings.

Oxygen
The following expenses are excluded from Coverage:

- Oxygen administered outside the United States and its territories;
- Oxygen furnished by an airline;

- Spare oxygen tanks;
- Preset portable oxygen systems; and
- Emergency or stand-by oxygen systems.

Pathologist Services Associated with Automated Clinical Laboratory Tests
Professional Services are not Covered when associated with automated clinical lab tests that do not require interpretation by the pathologist.

Personal Comfort, Hygiene, or Convenience Items and Services
Personal comfort, hygiene, or convenience items and Services that the Health Plan deems are not Medically Necessary and not directly related to Your treatment are excluded from Coverage. Examples of personal comfort, hygiene, or convenience items and Services include:

- Beauty and barber Services;
- Clothing, including support hose;
- Radio and television;
- Meals and accommodations;
- Telephone charges;
- Take-home supplies;
- Travel expenses (other than Medically Necessary Ambulance Services);
- Motel/hotel accommodations;
- Air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners, or any other similar equipment and devices used for environmental control or to enhance an environmental setting;
- Hot tubs, Jacuzzis, heated spas, or pools;
- Heating pads, hot water bottles, or ice packs;
- Physical fitness equipment;
- Hand rails and grab bars; and
- Massages and massage devices.

Private Duty Nursing Care
Private duty nursing care is excluded from Coverage, except as related to and set forth in the Home Health Care Services category of the **Covered Services** section of this Certificate.

Prosthetic Devices (External)
The following Prosthetic Device expenses are excluded from Coverage:

- Expenses for microprocessor controlled or myoelectric artificial limbs (e.g., C-legs);
- Expenses for cosmetic enhancements to artificial limbs; and
- Expenses for performance enhancing Prosthetic Devices (e.g., carbon-fiber racing legs).

Services, Supplies, Treatment, and Prescription Drugs
Services, supplies, treatment, and Prescription Drugs that are:

- Determined by the Health Plan to be not Medically Necessary;
- Not appropriately documented and/or substantiated in a corresponding medical record;
- Not specifically listed in the **Covered Services** section, unless such Services are specifically required to be Covered by federal law;
- Compounded medications (the process of combining, mixing, or altering ingredients to create a medication tailored to the needs of an individual patient). Compounding includes the combining of two (2) or more Drugs. Compounded Drugs are not FDA-approved;
- Court ordered care or treatment, unless otherwise Covered in this Individual Policy;
- For the treatment of a Condition resulting from:
    - War or an act of war, which does not include terrorism, whether declared or not;

- Participation in any act which would constitute a riot or rebellion, or a crime punishable as a felony;
- The Covered Person committing or attempting to commit an unlawful act or from the Covered Person engaging in an illegal occupation; and
- Service in the armed forces;

- Received prior to a Covered Person's Effective Date or received on or after the date a Covered Person's Coverage terminates under this Individual Policy, unless Coverage is extended in accordance with the **Administrative Provisions** section of this Certificate;
- Medical Services and supplies that are prescribed by, ordered by, or provided by Yourself or any person related to You by blood, marriage, Adoption, or Domestic Partnership;
- Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group;
- Non-medical Conditions related to hyperkinetic syndromes, learning disabilities, intellectual disability, or Inpatient Confinement for environmental change; or
- Supplied at no charge when health Coverage is not present, such as replaced blood, including whole blood, blood plasma, blood components, and blood derivatives.

Sexual Reassignment or Modification Services
Sexual reassignment and modification Services are excluded from Coverage except when considered Medically Necessary by the Health Plan and authorized in advance. This exclusion includes any Service or supply related to such treatment, including Prescription Drugs, unless such Service or treatment is deemed Medically Necessary.

Skilled Nursing Facilities ("SNFs")
SNF care is excluded when expenses are for an Inpatient admission to a SNF for purposes of Custodial Care, convalescent care, or any other Service primarily for Your convenience, that of Your family members, and/or the Provider. Expenses for any Inpatient days beyond the per person maximum listed on Your Schedule of Benefits are also excluded.

Sports-Related Devices and Services
Devices and Services used to affect performance primarily in sports-related activities are excluded from Coverage. All expenses related to physical conditioning programs, such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation are also excluded.

Sterility Reversal
Reversal of voluntary, surgically induced sterility, including the reversal of tubal ligations and vasectomies, is excluded from Coverage.

Therapy Services
Therapy Services provided on an Inpatient or outpatient basis, including Cardiac Therapy, pulmonary therapy, ST, OT, and PT, except as set forth in the **Covered Services** section of this Certificate, are excluded from Coverage. This exclusion includes any Service or supply intended to enhance or improve athletic or work performance unrelated to functional impairment.

Training and Educational Programs
Training and educational programs and materials, which include programs or materials for Pain Management, vision training, or vocational rehabilitation, except as provided under the Diabetes Outpatient Self-Management and Maternity categories of the **Covered Services** section of this Certificate, are excluded from Coverage.

Transplantation or Implantation Services and Supplies

Transplantation and implantation Services and supplies, including the Transplant or implant, other than those specifically listed in the **Covered Services** section of this Certificate, are excluded from Coverage. This exclusion includes any:

- Service or supply in connection with the implant of an artificial organ;
- Organ that is sold rather than donated to the Covered Person;
- Service or supply relating to any evaluation, treatment, or therapy involving the use of high-dose chemotherapy and autologous Bone Marrow Transplantation, autologous peripheral stem cell rescue, or autologous stem rescue for the treatment of any Condition that is considered experimental based on rules established by the Florida Agency for Health Care Administration ("AHCA") pursuant to Florida Statute; and
- Service or supply in connection with identification of a donor from a local, state, or national listing, except as specifically set forth for bone marrow donors in the **Covered Services** section of this Certificate.

Benefits are also not payable for, or in connection with, a Transplant if:

- The Health Plan is not contacted for Authorization prior to referral for Transplant evaluation of the procedure. Services will require Medical Necessity review through the Authorization process if the individual is evaluated prior to enrolling with the Health Plan;
- The Health Plan does not approve Coverage for the procedure;
- The Transplant procedure is performed in a Facility that has not been designated by the Health Plan as an approved Transplant Facility;
- The expenses are eligible to be paid under any private or public research fund, government program, or other funding program, whether or not such funding was applied for or received;
- The expenses are related to the transplantation of any non-human organ or tissue;
- The expenses are related to the donation or acquisition of an organ for a recipient who is not Covered by the Health Plan, except as specifically Covered herein for Bone Marrow Transplants only;
- A denied Transplant that is performed. This includes follow-up care, immunosuppressive Drugs, and complications of such Transplant;
- Any Bone Marrow Transplant, as defined herein, which is not specifically listed the regulations or covered by Medicare pursuant to a national coverage decision made by CMS as evidenced in the most recently published Medicare Coverage Issues Manual; and
- Any Service in connection with identification of a donor from a local, state, or national listing, except in the case of a Bone Marrow Transplant.

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

- Artificial heart devices, unless Medically Necessary and authorized in advance by the Health Plan;
- Drugs used in connection with diagnosis or treatment leading to a Transplant when such Drugs have not received FDA approval for such use; and
- Transplant expenses not authorized in advance by the Health Plan.

Transportation Services
Transportation Services that are non-emergent and not Covered by Medicare are excluded from Coverage. Transportation Services may be Covered in connection with an approved Transplant procedure as outlined in the Transplant Services category in the **Covered Services** section of this Certificate.

Travel or Vacation Expenses
Travel and vacation expenses, even if prescribed or ordered by a Provider, are excluded from Coverage.

Vision Services
Health Care Services to diagnose or treat vision problems that are not direct consequences of trauma or prior ophthalmic surgery, eye examinations, eye exercise or visual training, eyeglasses, and contact lenses and their fittings, are not Covered. In addition, any surgical procedure performed primarily to correct or improve myopia (near sightedness), hyperopia (farsightedness), or astigmatism (blurring), exams for the correction of vision, and radial keratotomy eye surgery, including visual acuity improvements and related procedures to correct refractive errors, are excluded from Coverage.

This exclusion does not include Services described in the Vision Services and Pediatric Vision Services categories of the **Covered Services** section of this Certificate.

Volunteer Services
Volunteer Services, or Services which would normally be provided free of charge, are excluded from Coverage.

Weight Control Services
Weight control Services, except for Physician counseling Services, are excluded from Coverage. This exclusion includes weight control/loss programs, dietary regimens, food or food supplements, exercise programs, exercise or other equipment, gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict Your ability to assimilate food.

Wigs or Cranial Prosthesis
Wigs and cranial prosthesis, except when related to restoration after cancer or brain tumor treatment, are excluded from Coverage.

C. GENERAL EXCLUSIONS

General exclusions include:

- Any Health Care Service received prior to Your Effective Date or after the date Your Coverage terminates;
- Any Health Care Service not within the Covered Services categories described in the **Covered Services** section of this Certificate, unless such Services are specifically required to be Covered by applicable law;
- Medical Services and supplies that are prescribed by, ordered by, or provided by Yourself or any person related to You by blood, marriage, Adoption, or Domestic Partnership;
- Any Health Care Service which is not Medically Necessary as defined in this Certificate and determined by Us. The ordering of a Service by a Health Care Provider does not, in itself, make such Service Medically Necessary or a Covered Service;
- Any Health Care Service rendered at no charge;
- Any Health Care Service to diagnose or treat any Condition which initially occurred while You were (or which, directly or indirectly, resulted from, or is in connection with, You being) under the influence of alcoholic beverages, any chemical substance set forth in Florida Statutes, or any substance controlled under Florida Statutes. Notwithstanding, this exclusion shall not apply to the use of any Prescription medication by You if such medication is taken on the specific advice of a Physician in a manner consistent with such advice; and
- Any Health Care Service to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:
    - War or an act of war, whether declared or not;
    - Your participation in, or commission of, any act punishable by law as a felony whether or not You are charged or convicted, or which constitutes riot, or rebellion;

- Your engaging in an illegal occupation or committing or attempting to commit a felony;
- Services received to treat a Condition arising out of Your service in the armed forces, reserves, and/or National Guard;
- You being under the influence of alcohol or any narcotic, unless taken on the specific advice of a Physician in a manner consistent with such advice;
- Services that are not patient-specific, as determined solely by Us;
- Health Care Services rendered because they were ordered by a court, unless such Services are Covered Services under this Certificate; and
- Any Health Care Service rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.

VI. UNDERSTANDING YOUR SHARE OF HEALTH CARE EXPENSES

This section explains what Your share of the health care expenses will be for Covered Services You receive. In addition to the information explained in this section, it is important that You refer to Your Schedule of Benefits to determine Your share of the cost with regard to Covered Services.

A. DEDUCTIBLE REQUIREMENTS

This Individual Policy has both an individual Calendar Year Deductible and a family Calendar Year Deductible. However, a family Deductible only applies if You have family Coverage (i.e., Coverage for an Insured and one (1) or more Covered Dependents under this Certificate).

A Deductible is a specific annual dollar amount that You must pay for Covered benefits received each Calendar Year. This amount, when applicable, must be satisfied by You each Calendar Year before any benefits subject to the Deductible are payable by Us. The Calendar Year Deductible may continue to accumulate through the Calendar Year, regardless of the Effective Date or if You enroll in a different individual plan offered by the Health Plan mid-year due to eligible circumstances. If You enroll in a Medicare plan offered by the Health Plan mid-year due to eligible circumstances, then the Calendar Year Deductible will reset, effective the first day of Your new Coverage.

Only those charges indicated on Claims We receive for Covered Services will be credited toward the Calendar Year Deductible and only up to the Allowed Amount. Covered Services that are subject to the Calendar Year Deductible under this Individual Policy are listed in the Schedule of Benefits.

The following out-of-pocket expenses will not count towards satisfying the Calendar Year Deductible requirement:

- Expenses related to charges for Services not Covered by this Individual Policy;
- Any charges in excess of the Allowed Amount;
- Expenses that relate to Services that exceed specific treatment limitations explained in the **Covered Services** section of this Certificate or noted in the Schedule of Benefits; and
- Pharmaceutical manufacturer sponsored patient assistance programs (“PAPs”) do not count towards the Calendar Year Deductible.

Covered Prescription Drugs may also be subject to a Calendar Year Deductible. Some plans include a separate Deductible for Covered Prescription Drugs, while others include a single Deductible that applies to both Covered medical Services and Prescription Drug expenses. The Prescription Drug Coverage under this Individual Policy is listed in the Schedule of Benefits.

INDIVIDUAL CALENDAR YEAR DEDUCTIBLE

This amount, when applicable, must be satisfied by each Covered Person each Calendar Year before any payment will be made by the Health Plan for benefits subject to the Deductible. If You meet Your individual Deductible, then Covered benefits that are subject to that Deductible are Covered for You by the Health Plan for the remainder of the Calendar Year. Only those charges indicated on Claims We receive for Covered Services will be credited toward the individual Calendar Year Deductible and only up to the applicable Allowed Amount.

Note: If You have family Coverage under a qualifying High Deductible Health Plan ("HDHP") (HSA compatible), the individual Calendar Year Deductible is not applicable. Rather, the family Calendar Year Deductible must be satisfied, as described below, before any payment will be made by the Health Plan for benefits subject to the Deductible.

FAMILY CALENDAR YEAR DEDUCTIBLE

If You have family Coverage (i.e., Coverage for an Insured and one (1) or more Covered Dependents under this Certificate), Your plan includes a family Calendar Year Deductible. If You are an Insured not Covered by a qualifying HDHP (HSA compatible) with a family Deductible, Your Deductible can be satisfied in one (1) of two (2) ways:

- If You meet Your individual Deductible, then Covered benefits that are subject to that Deductible are Covered for You by the Health Plan for the remainder of the Calendar Year; or
- If any number of Covered Persons in Your family collectively meet the family Deductible, then Covered benefits that are subject to the Deductible are Covered for You and all Covered Dependents by the Health Plan for the remainder of the Calendar Year.

The maximum amount that any one (1) Covered Person in Your family can contribute toward the family Calendar Year Deductible is the amount applied toward the individual Calendar Year Deductible, unless You are Covered by a qualifying HDHP (HSA compatible).

If You are a Covered Person Covered by a qualifying HDHP (HSA compatible), You are not subject to an embedded individual Calendar Year Deductible as described above for Covered family units. Instead, family Covered Persons must meet the combined family Calendar Year Deductible before any benefits subject to the Deductible are payable by the Health Plan.

Please see Your Schedule of Benefits for more information about this Individual Policy's Deductibles.

B. COPAYMENT REQUIREMENTS

For some Covered Services, the Covered Person is responsible for paying a flat dollar amount. This dollar amount is referred to as a Copayment. Copayments are due at the time of service. The Health Plan is not responsible for the coordination and collection of Copayments. The Provider is responsible for the collection of Copayments at the time Services are rendered. The Copayment requirements for this Individual Policy are set forth in the Schedule of Benefits. Listed below is a brief description of some of the Copayment requirements that may apply to Your Coverage.

In some cases, when Our Allowed Amount or the Provider's actual charge for a Covered Service rendered is less than the Copayment amount, You may be responsible for the lesser of Our Allowed Amount or the Provider's actual charge for the Covered Service.

OFFICE SERVICES COPAYMENT

Services provided by a Physician or other qualified Health Care Provider in an office setting are Covered as indicated in the Schedule of Benefits. Office visit Services may include the provision of evaluation and management ("E/M") Services, Preventive care, immunizations, injections, diagnostic Services, minor surgery, and certain therapy Services. An office visit Copayment may apply when an E/M Service is provided, or when an E/M Service is not provided but a non-

diagnostic procedure is performed that does not have a specific Cost-Share requirement. Additional Cost-Sharing may apply to other Services provided during an office visit, such as diagnostic tests, medications, allergy Services, and therapy Services.

INPATIENT FACILITY SERVICES COPAYMENT

The Copayment for Inpatient Facility Services, if applicable to Your Certificate, must be satisfied by You for each Inpatient admission to a Hospital or Psychiatric Facility before any payment will be made by the Health Plan for any Claim for Inpatient Covered Services, unless specifically stated otherwise on Your Schedule of Benefits. The Copayment for Inpatient Facility Services, if applicable to Your Certificate, applies, regardless of the reason for the admission, and applies to all Inpatient admissions to a Hospital or Psychiatric Facility within or outside the Service Area.

Note: Copayments for Inpatient Facility Services may vary depending on the Facility chosen. Please see Your Schedule of Benefits for more information.

OUTPATIENT FACILITY SERVICES COPAYMENT

The Copayment for outpatient Facility Services, if applicable to Your Individual Policy, must be satisfied by You and applies, regardless of the reason for the visit, for each outpatient visit to a Hospital or Ambulatory Surgical Center before any payment will be made by the Health Plan for any Claim for outpatient Covered Services. Cost-Share for additional Services provided during the visit or stay may apply.

Note: Copayments for outpatient Facility Services may vary depending on the Facility chosen and the Services received. Please see Your Schedule of Benefits for more information.

EMERGENCY ROOM FACILITY SERVICES COPAYMENT

The Copayment for emergency room Facility Services, if applicable to Your Certificate, applies, regardless of the reason for the visit, and applies to emergency room Facility Services within or outside the Service Area. The Copayment for emergency room Facility Services, if applicable to Your Individual Policy, must be satisfied by You for each visit. If You are admitted to the Hospital as an Inpatient at the time of the emergency room visit, the Copayment for emergency room Facility Services, if applicable to Your Certificate, will be waived, but You will still be responsible for Your share of the expenses for Inpatient Facility Services as listed in Your Schedule of Benefits.

C. THE COINSURANCE PERCENTAGE

After satisfaction of the Calendar Year Deductible, the Covered Person may be responsible for paying a percentage of the Allowed Amount for Covered Services. This percentage that the Covered Person is responsible for is called the Coinsurance Percentage. For Services that are subject to Coinsurance, the Coinsurance Percentage of the applicable Allowed Amount You are responsible for is listed in Your Schedule of Benefits.

When charges are incurred for Covered Services or supplies provided by Participating Providers, this Individual Policy calculates all Coinsurance amounts by applying the Coinsurance Percentage to the amount the Participating Provider has agreed to accept for that Service or supply in the negotiated fee schedule.

D. OUT-OF-POCKET MAXIMUM EXPENSE LIMIT

The Out-of-Pocket Maximum Expense Limit, as set forth in the Schedule of Benefits, is the maximum amount of expenses that You must pay in a Calendar Year before this Individual Policy pays for all Covered Services and Covered Prescription Drugs at one hundred percent (100%) of the Allowed Amount for the remainder of the Calendar Year. The Out-of-Pocket Maximum Expense Limit may continue to accumulate through the Calendar Year, regardless of the plan Effective Date or if You enroll in a different individual plan offered by the Health Plan mid-year due to eligible

circumstances. If You enroll in a group or Medicare plan offered by the Health Plan mid-year due to eligible circumstances, then the Out-of-Pocket Maximum Expense Limit will reset, effective the first day of Your new plan Coverage.

All of a Covered Person's Cost-Sharing for Covered Services and Covered Prescription Drugs, including any applicable Calendar Year Deductible, Copayments, and Coinsurance, contribute toward the Out-of-Pocket Maximum Expense Limit. Unless Your Prescription Drug Coverage includes a separate Out-of-Pocket Maximum Expense Limit, the Out-of-Pocket Maximum Expense Limit set forth on Your Schedule of Benefits will apply to both Covered Medical Services and Covered Prescription Drugs.

The following out-of-pocket expenses will not count towards satisfying the Out-of-Pocket Maximum Expense Limit:

- Expenses related to charges for Services and Prescription Drugs not Covered by this Individual Policy;
- Any charges in excess of the Allowed Amount;
- Expenses that relate to Services that exceed specific treatment limitations explained in the **Covered Services** section of this Certificate or noted in the Schedule of Benefits; and
- PAPs do not count towards the Out-of-Pocket Maximum Expense Limit.

The application of any specific Service limits or specific benefit maximums noted in the **Covered Services** section of this Certificate or in the Schedule of Benefits is not affected by satisfaction of the Out-of-Pocket Maximum Expense Limit. These specific Service provisions will still apply after the Out-of-Pocket Maximum Expense Limit is satisfied.

This Individual Policy has both an individual Out-of-Pocket Maximum Expense Limit and a family Out-of-Pocket Maximum Expense Limit. However, a family Out-of-Pocket Maximum Expense Limit only applies if You have family Coverage (i.e., Coverage for an Insured and one (1) or more Covered Dependents under this Certificate).

INDIVIDUAL CALENDAR YEAR OUT-OF-POCKET MAXIMUM EXPENSE LIMIT

Once You have reached the individual Calendar Year Out-of-Pocket Maximum Expense Limit listed in Your Schedule of Benefits, You will have no additional out-of-pocket responsibility for the remainder of that Calendar Year for Covered Services, and We will pay one hundred percent (100%) of the Allowed Amount for Covered Services rendered during the remainder of that Calendar Year.

FAMILY CALENDAR YEAR OUT-OF-POCKET MAXIMUM EXPENSE LIMIT

If You have family Coverage (i.e., Coverage for an Insured and one (1) or more Covered Dependents under this Certificate), Your plan includes a family Out-of-Pocket Maximum Expense Limit. Your family Calendar Year Out-of-Pocket Maximum Expense Limit can be satisfied in one (1) of two (2) ways:

- If You meet Your individual Out-of-Pocket Maximum Expense Limit, then Covered benefits will be paid by the Health Plan at one hundred percent (100%) of the Allowed Amount for You for the remainder of the Calendar Year; or
- If any number of Covered Persons in Your family collectively meet the family Out-of-Pocket Maximum Expense Limit, then Covered benefits will be paid by the Health Plan at one hundred percent (100%) of the Allowed Amount for You and all Covered Dependents for the remainder of the Calendar Year.

The maximum amount any one (1) Covered Person in Your family can contribute toward the family Calendar Year Out-of-Pocket Maximum Expense Limit, if applicable, is the amount applied toward the individual Calendar Year Out-of-Pocket Maximum Expense Limit. Please see Your Schedule of Benefits for more information.

E. ADDITIONAL EXPENSES YOU MUST PAY

In addition to Your share of the expenses described above, You are also responsible for:

- The Premium applicable to Your Coverage;
- Expenses incurred for non-Covered Services;
- Charges in excess of any maximum benefit limitation listed in this Certificate or Your Schedule of Benefits;
- Payment of expenses for Claims denied because We did not receive information requested from You regarding whether or not You have other Coverage and the details of such Coverage;
- Any benefit reductions; and
- Charges for Health Care Services or Prescription Drugs, which are excluded.

VII. CLAIM PROVISIONS

A Claim is any request for a plan benefit or benefits made in accordance with the Claim procedures described herein. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a Claim under these procedures.

A. REIMBURSEMENT FOR PARTICIPATING AND NON-PARTICIPATING PROVIDER SERVICES

The Health Plan will provide or arrange for Services to be received from Participating Providers through a contractual arrangement. If a Covered Person receives Services from a Participating Provider (as published in the Provider/Pharmacy Directory), the Health Plan will pay the Health Care Provider directly for all care received. The Covered Person will not have to submit a Claim for payment and will be responsible only for any applicable Deductibles, Copayments, and Coinsurance.

In the event the Covered Person receives Emergency Services or Care from a Non-Participating Provider that has not entered into an agreement with the Health Plan to provide access at a discount from the billed amount of that Provider, payment shall be:

- The contract status of the Non-Participating Provider will be verified with the Health Plan's extended Network. If the Provider is contracted with the extended Network, the Claim will be reimbursed based on that contract;
- The charge mutually agreed to by the Health Plan and the Provider within sixty (60) days of the Claim submittal utilizing the Medicare Allowable amount as guidance;
- The median of the contracted rate on January 31, 2019 for the same or similar items or Service, increased for inflation according to the Qualified Payment Amount ("QPA") calculation methodology; or
- Lesser of the Provider's billed charges.

Such payment shall be the net of any applicable In-Network Cost-Share.

Notwithstanding the provisions in this section, the Health Plan is entitled to reimbursement from the Covered Person in accordance with Florida Statutes, or the decision of a court of competent jurisdiction.

Covered Persons will be held harmless for Balance Billing (i.e., charges in excess of their In-Network Cost-Sharing amount), Surprise Bills, and for the following Services received within the United States: Emergency Services, Care received in a Facility (Hospital, Ambulatory Surgical Center, or Urgent Care Center), and air ambulance Services.

PAYMENT OF CLAIMS FOR OUT-OF-NETWORK EMERGENCY SERVICES:

No later than thirty (30) calendar days after the bill for such items or Services is transmitted by the Provider, the Health Plan shall send to the Provider an initial payment or notice of denial of payment. The Health Plan will pay a total plan of coverage payment amount, and will count it towards any In-Network Out-of-Pocket Maximum Expense Limit.

B. FOUR TYPES OF CLAIMS

As described below, there are four (4) categories of Claims that can be made under this Individual Policy, each with somewhat different Claim and Appeal rules. There are different requirements based on the type of Claim involved. The primary difference is the time frame within which Claims and Appeals must be determined.

It is very important to follow the requirements that apply to Your particular type of Claim. If You have any questions regarding what type of Claim and/or what Claims procedure to follow, contact the Health Plan's Customer Service Department at 1.855.443.4735.

PRE-SERVICE CLAIM

A Claim is a Pre-Service Claim if the Health Plan specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the Claim involves Urgent Care, as defined below. Benefits under the Individual Policy that require approval in advance are specifically noted in this Certificate as being subject to Prior Authorization.

URGENT CARE CLAIM

An Urgent Care Claim is a Pre-Service Claim for medical care or treatment in which the application of the standard Pre-Service time periods could seriously jeopardize the Covered Person's life, health, or ability to regain maximum function or would, in the opinion of a Physician with knowledge of the Covered Person's medical Condition, subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

On receipt of a Pre-Service Claim, the Health Plan will make a determination of whether it involves Urgent Care, provided that, if a Physician with knowledge of the Covered Person's medical Condition determines that a Claim involves Urgent Care, the Claim shall be treated as an Urgent Care Claim.

POST-SERVICE CLAIM

A Post-Service Claim is any Claim for a benefit under the Individual Policy that is not a Pre-Service Claim, an Urgent Care Claim, or a Concurrent Care Claim. This means requests for reimbursement or payment of costs for Services already provided.

CONCURRENT CARE CLAIMS

A concurrent care decision occurs when the Health Plan has approved an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two (2) types of Concurrent Care Claims: (1) when reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and (2)

when an extension is requested beyond the initially approved period of time or number of treatments.

C. HOW TO FILE A CLAIM FOR BENEFITS

Except for Urgent Care, Pre-Service, and Concurrent Care Claims discussed below, a Claim for plan benefits is made when a Covered Person (or authorized representative) submits a written Medical Reimbursement Form to the Benefits Reimbursement Unit or a Prescription Drug Reimbursement Form to the Pharmaceutical Services Department. An itemized receipt for the Services or supplies rendered, along with written proof of payment made, is required to be submitted with the form. The request for reimbursement must include the name of the Covered Person, the policy number, and the Covered Person's signature.

Reimbursement forms are available from the Health Plan's Customer Service Department. Forms are also available on the Health Plan's website at hf.org/healthplans. A reimbursement form will be acknowledged on the date that the Health Plan receives the completed form.

Reimbursement requests for medical Services must be sent to:

Mail: 6450 U.S. Highway 1,
Rockledge, FL 32955
ATTN: Benefits Reimbursement Unit

Fax: 321.434.5655
ATTN: Benefits Reimbursement Unit

Reimbursement requests for Prescription Drugs must be sent to:

Pharmacy Department
6450 U.S. Highway 1,
Rockledge, FL 32955

POST-SERVICE CLAIMS

A Post-Service Claim must be filed within six (6) months following receipt of the medical service, treatment, or product to which the Claim relates. With respect to Prescription Drug benefits, Cost-Sharing provisions, including Deductible, Copayments, and Coinsurance for Prescription Drug benefits, are typically applied by the Pharmacy when a Prescription is filled, and no further action is required on the part of the Covered Person. However, if a participant believes the Pharmacy has applied the wrong Cost-Sharing amount, the Covered Person may pay the amount, as determined by the Pharmacy, and submit a Claim for reimbursement, following the procedures for Post-Service Claims above. Reimbursement requests when a discount card or coupon card (other than a Drug manufacture card) was used, cannot be processed with insurance and any amounts paid out-of-pocket will not apply towards Your Deductible or maximum out-of-pocket accumulators.

It is not expected that a Covered Person will make payment, other than their required Cost-Share, for any benefits provided herein. However, if such payments are made, the Covered Person shall submit a timely Claim for reimbursement as outlined above. In order for a Claim for reimbursement to be considered, the Covered Person must provide a completed Medical or Prescription Drug Reimbursement Form, written proof of any payment made in a form acceptable by the Health Plan, and an itemized receipt. The Benefit Reimbursement Unit reserves the right to request additional documentation in support of Claim or reimbursement requests. Claims submitted after the six (6) month deadline will be denied.

URGENT CARE CLAIMS

Considering the expedited time frames for decision of Urgent Care Claims, an Urgent Care Claim for benefits may be submitted to the Health Plan's Medical Management Department by faxing the request to 1.855.328.0059, ATTN: Medical Management. Verbal requests may be made by calling the Health Plan's Customer Service Department at 1.855.443.4735.

The Claim should include the following information:

- The identity of the Covered Person;
- A specific medical Condition or symptom; and
- A specific treatment, Service, or product for which approval or payment is requested.

D. CLAIMS REVIEW AND DECISION

The Health Plan will pay, deny, or request additional information for a Claim within twenty (20) calendar days from the day it is received for electronic Claims and within forty (40) calendar days from the day it is received for paper Claims.

The Health Plan shall reimburse all Claims or any portion of any Claim up to the Allowed Amount, within the time frames established by applicable federal and state statutes, regulations, and regulatory guidelines. If a Claim or a portion of a Claim is contested by the Health Plan, the Covered Person or Covered Person's assignees shall be notified, in writing, that the Claim is contested or denied. The notice (Explanation of Benefits) that a Claim is contested shall identify the contested portion of the Claim and the reasons for contesting the Claim. Upon receipt of the additional information requested from the Covered Person or Covered Person's assignees, the Health Plan shall pay or deny the contested Claim, or portion of the contested Claim, within the established time frames. The Health Plan shall pay or deny all Claims no later than one hundred and twenty (120) days after receiving an electronic Claim and one-hundred and forty (140) days after receiving a paper Claim.

Payment will be acknowledged on the date that it is received by the Health Plan. All overdue payments shall bear a simple interest rate as directed by the State of Florida.

Upon written notification by a Covered Person, the Health Plan shall investigate any Claim of improper billing by a Physician, Hospital, or other Health Care Provider. The Health Plan shall determine if the Covered Person was properly billed for only those procedures and Services that the Covered Person actually received. If the Health Plan determines that the Covered Person has been improperly billed, the Health Plan shall notify the Covered Person and the Provider of its findings and shall reduce the amount of payment to the Provider by the amount determined to be improperly billed.

Benefits will be paid to the Covered Person. Benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the Covered Person's estate.

E. COORDINATION OF BENEFITS ("COB")

COB is a limitation of Coverage and/or benefits to be provided by Us. This provision is required by and subject to applicable federal and/or state law concerning coordination of health insurance benefits and will be modified to the extent necessary to enable Us to comply with such laws.

COB determines the manner in which expenses will be paid when You are covered under more than one (1) health plan, program, or policy providing benefits for health care services. It is Your responsibility to provide Us and Your Physician with information concerning any duplication of coverage under any other health plan, program, or policy You or Your Covered Dependents may have. This means You must notify Us in writing if You have other applicable coverage or if there is

no other coverage. You may be requested to provide this information at the time You apply for this Certificate, annually during renewal, or in connection with a specific health care service You receive. If We do not receive the information We request from You, We may deny Your Claims, and You will be responsible for payment of any expenses related to denied Claims.

COB is designed to avoid the costly duplication of payment for health care services and/or supplies under multiple health coverage plans. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all plans does not exceed one hundred percent (100%) of the total Allowable expense. When We pay as the Secondary Plan, We do not pay until after the Primary Plan has paid its benefits. We will then pay part or all of the Allowable expenses left unpaid, based on the Covered benefit as outlined in the Schedule of Benefits.

PLANS AFFECTED

If any of the other health coverage plan(s), a Covered Person has, covers at least a portion of Health Care Services or supplies Covered under this Individual Policy, coordination may take place. Not all health coverage plans will be considered in this coordination process. The plans that will be considered for coordination are the following:

- Any group insurance, group-type self-insurance, or HMO/Point-of-Service ("POS") plan, including coverage under labor-management, trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans;
- Any service plan agreements, group practice, individual practice, or other prepayment coverage on a group basis;
- An insurance agreement, including an automobile insurance agreement or Workers' Compensation; and
- Any coverage under governmental programs, including Medicare, and any coverage required or provided by any statute.

Each policy, plan, or other arrangement for benefits or services that the Covered Person has will be considered separately with respect to that portion of any such policy, agreement, or other arrangement which reserves the right to take the benefits or services of other programs into consideration in determining its benefits and that portion which does not.

The amount of Our payment, if any, when We coordinate benefits under this section, is based on whether or not We are the primary payer. When We are primary, We will pay for Covered Services without regard to coverage under other plans. When We are not primary, Our payment for Covered Services may be reduced so that the total benefits under all Your plans will not exceed one hundred percent (100%) of the total reasonable expenses actually incurred for Covered Services. The Health Plan will use the lesser Allowed Amount of the two (2) policies. In the event of coordinating with Medicare as the primary plan, the Medicare Allowable will be used.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed as a benefit paid.

ORDER OF BENEFIT DETERMINATION

If the health benefits of all of the health coverage plans the Covered Person is covered under would have exceeded the actual cost of the services or supplies rendered in the absence of this provision, this coordination process will reduce the payment by one (1) or more of the plans to eliminate the excess payment. The following guidelines will be used to determine the order of benefit payments:

- The benefits of a plan that covers the individual are determined before those of the plan which covers the individual as a dependent.
- The parents' birth dates.
  - Parents not separated or divorced:
    - The benefits of the parent's plan whose date of birth, excluding year of birth, occurs earlier in the Calendar Year shall be determined before the benefits of the plan of the parent whose date of birth, excluding year of birth, occurs later in the Calendar Year.
    - If either parents' plan does not have a similar "birthday rule" provision, the criteria shall not be applied, and the rule set forth in the plan which does not have the "birthday rule" provision shall determine the order of benefits.
  - Parents are separated or divorced:
    - When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of the plan of the parent with custody will cover the child before the benefits of the plan of the parent without custody.
    - When the parents are divorced and the parent with custody of the child has remarried, the benefits of the plan of the parent with custody shall be determined before the benefits of a plan which cover that child of the step-parent; and the benefits of a plan which cover that child of a step-parent will be determined before the benefits of a plan which covers the child of the parent without custody.
    - If there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of the parent with such financial responsibility shall be determined before the benefits of any other program which covers the child.
- When rules 1, 2, or 3 do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period shall be determined before the plan which has covered such person the shorter period of time, provided that:
  - The benefits of the plan covering the person as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other plan covering such person as an active employee; and
  - If either program does not have a provision regarding laid-off or retired employees, which results in each program determining its benefits after the other, then the provision above shall not apply.

When this coordination process reduces the total amount of benefits otherwise payable to a Covered Person under this Individual Policy, each benefit that would be payable in the absence of this provision will be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Certificate.

F. THIRD PARTY LIABILITY AND RIGHT OF RECOVERY

If the Health Plan provided Covered Health Care Services or other benefits or Services for a Covered Person who suffers injury, disease, or illness, by virtue of the negligent act or omission of a Third Party, We are entitled to reimbursement from the Covered Person in accordance with Florida Statutes.

A Third Party is defined to include any of the following:

- The party or parties who caused the illness, Sickness, or bodily Injury;

- The insurer or other indemnifier of the party or parties who caused the illness, Sickness, or bodily Injury;
- A guarantor of the party or parties who caused the illness, Sickness, or bodily Injury;
- The Covered Person's own insurer (e.g., in the case of uninsured, underinsured, medical payments, or no-fault Coverage);
- A Workers' Compensation insurer; and
- Any other person, entity, policy, or plan that is liable or legally responsible in relation to the illness, Sickness, or bodily Injury.

When the Health Plan is obligated to and does pay for or arrange for Covered Health Care Services that a Third Party is liable or legally responsible to pay for, the Health Plan may:

- Subrogate, that is, take over the Covered Person's right to receive payments from the Third Party. The Covered Person will transfer to the Health Plan any rights he/she may have to take legal action arising from the illness, Sickness, or bodily Injury to recover any sums paid under the Health Plan on behalf of the Covered Person; and/or
- Recover from the Covered Person any benefits paid under the Health Plan on the Covered Person's behalf out of the recovery made from the Third Party whether paid directly or indirectly to You/the Insured, his/her Spouse, dependents, beneficiaries, or estate, whether held in trust or constructive trust for the benefit of You/the Insured, his/her Spouse, dependents, beneficiaries, or estate by lawsuit, settlement, or otherwise.

The Covered Person and his/her legal representative must cooperate fully with the Health Plan in regard to subrogation and recovery rights. The Covered Person and his/her legal representative will, upon request from the Health Plan, provide all information and sign and return all documents necessary to exercise the Health Plan's rights under this provision. The Health Plan's subrogation and recovery rights are not contingent upon the receipt of such documents. The Covered Person and his/her legal representative will do nothing to prejudice the Health Plan's rights.

The Health Plan will have a first lien upon any recovery, whether by settlement, judgment, mediation, arbitration, or otherwise, that the Covered Person receives (whether paid directly or indirectly to You/the Insured, the Spouse, dependents, beneficiaries, or estate, whether held in trust or constructive trust for the benefit of You/the Insured, the Spouse, dependents, beneficiaries, or estate) or is entitled to receive from a Third Party (whether or not such recovered funds are designated as payment for medical expenses). This lien will not exceed:

- The amount of benefits paid by the Health Plan for the illness, Sickness, or bodily Injury, plus the amount of all future benefits which may become payable under the Health Plan which result from the illness, Sickness, or bodily Injury. The Health Plan will have the right to offset or recover such future benefits from the amount received from the Third Party;
- If the benefits were Covered by a capitation fee, the fee-for-service equivalent, determined on a just and equitable basis as provided by law; or
- The amount recovered from the Third Party.

Upon recovery from the Third Party due to settlement, judgment, mediation, arbitration, or otherwise, the Covered Person and his/her legal representative agrees to hold in a separate trust, for the benefit of the Health Plan, an amount equal to the Health Plan's first lien on the total recovery. In addition, the Covered Person and his/her legal representative agrees to hold the first lien amount in trust until such time as the Health Plan's first lien has been satisfied by payment of the first lien amount to the Health Plan.

If the Covered Person or his/her legal representative makes any recovery from a Third Party and fails to reimburse the Health Plan for any benefits which arise from the illness, Sickness, or bodily Injury, then:

- The Covered Person and his/her legal representative will be liable to the Health Plan for the amount of the benefits paid under the Individual Policy;
- The Covered Person and his/her legal representative will be liable to the Health Plan for the costs and attorneys' fees incurred by the Health Plan in collecting those amounts; and
- The Health Plan may reduce future benefits payable by the Individual Policy for any illness, Sickness, or bodily Injury, up to the amount of the payment that the Covered Person has received from the Third Party.

The Health Plan's recovery rights and first lien rights will not be reduced due to the Covered Person's own negligence or due to the attorney's fees and costs. The Health Plan's recovery rights and first lien rights will not be reduced due to the Covered Person not being made whole. The "make whole" doctrine or rule does not apply and is specifically excluded under this Certificate.

For clarification, this provision for third party liability, subrogation, and right of recovery applies to the Covered Person, which is defined under the Certificate to include the Insured and all Covered Dependents, and to any recovery from the Third Party by or on behalf of the estate of the Covered Person.

G. RIGHT TO RECEIVE AND RELEASE INFORMATION

The Health Plan has the right to receive and release necessary information to administer this Individual Policy. By accepting Coverage under this Individual Policy, the Covered Person gives permission for the Health Plan to obtain from or release to any insurance company or other organization or person any information necessary to determine whether this provision or any similar provision in other plans applies to a Claim and to implement such provisions. Any person who claims benefits under this Certificate agrees to furnish to the Health Plan information that may be necessary to implement this provision.

H. RIGHT OF RECOVERY

If the Health Plan makes larger payments than are required under this Individual Policy, then the Health Plan has the right to recover any excess benefit payment from any person to whom such payments were made.

I. NON-DUPLICATION OF GOVERNMENT PROGRAMS

The benefits of this Individual Policy shall not duplicate any benefits that are received or paid to the Covered Person under governmental programs, such as Medicare, Veterans Administration, TRI-CARE ("CHAMPUS"), Medicaid, or any Workers' Compensation Act, to the extent allowed by law. In any event, if this Individual Policy has duplicated such benefits, all sums paid or payable under such programs shall be paid or payable to the Health Plan to the extent of such duplication.

Charges for expenses in connection with any Condition for which a Covered Person has received, whether by settlement or by adjudication, any benefit under Workers' Compensation or Occupational Disease Law or similar law are not Covered by the Health Plan. If the Covered Person enters into a settlement giving up rights to recover past or future medical benefits under Workers' Compensation law, this Individual Policy will not Cover past or future medical Services that are the subject of or related to that settlement. In addition, if the Covered Person is covered by a Workers' Compensation program that limits benefits if other than specified Health Care Providers are used, and the Covered Person receives care or services from a Health Care Provider not specified by the program, the Health Plan will not Cover the balance of any costs remaining after the program has paid.

J. ADVERSE DETERMINATIONS

A decision on a Claim is "Adverse" if it is: (a) a denial, reduction, or termination of; or (b) a failure to provide or make payment (in whole or in part) for a plan benefit. If a Claim is denied for any

reason, the Covered Person will receive a notice explaining the reason for the denial and the process for filing an Appeal as further provided in this Certificate. A Covered Person has a right to Appeal an Adverse Determination under these Claims and Appeal procedures.

Within sixty (60) days after Your Claim is received, You will receive a written notice (Explanation of Benefits) of the decision. If Your Claim is denied, in whole or in part, the Benefit Reimbursement Unit will further notify You of Your right to additional review of Your denied Claim.

If Your request for review is denied in whole or in part and You still disagree with the decision, within one (1) year of the date You receive written notice, You must deliver to the Health Plan a written request for a final Claims determination to:

Mail: Health First Health Plans
ATTN: Appeals Coordinator
6450 U.S. Highway 1
Rockledge, FL 32955

Fax: 321.434.4769
ATTN: Appeals Coordinator

Email: hfhpinfo@hf.org

Your request for a final Claims determination should include any documentation supporting Your Claim.

K. ELIGIBILITY, ENROLLMENT, AND RESCISSION OF COVERAGE

All Claims or disputes regarding You and/or dependent's eligibility and enrollment, including removal from Coverage due to failure to provide documentation supporting eligibility, must be submitted in writing to the Benefits Reimbursement Unit (see the **How to File a Claim for Benefits** section above for the mailing address).

For Claim disputes relating to dependents removed from Coverage due to failure to provide documentation substantiating their eligibility, You should include the documentation that will prove the dependent is eligible along with Your letter. If approved, Coverage will be reinstated, at the Health Plan's discretion, either retroactively sixty (60) days from the date You submit Your Appeal or the date Your dependent was removed from Coverage. In this event, if Your Coverage level changed, contributions for Coverage will be collected from the date Coverage was reinstated. You will be responsible for any Claims incurred between the time Coverage ended and the date it was reinstated.

L. PHYSICAL EXAMINATIONS AND AUTOPSY

The Health Plan has the right to require medical exams be performed on any individual for whom a Claim is pending as often as the Health Plan may reasonably require. The Health Plan also has the right to request an autopsy in the case of death, if state law so permits. If the Health Plan requires a medical exam or autopsy, it will be performed at the Health Plan's expense.

M. LEGAL ACTIONS AND LIMITATIONS

No legal action may be brought to recover on this Individual Policy within sixty (60) days after written proof of loss has been given, as required, by this Individual Policy. No such action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

N. UNUSUAL CIRCUMSTANCES

If the rendering of Services or benefits payable under this Individual Policy is delayed or impractical due to:

- Complete or partial destruction of Network Facilities;
- War;

- Riot;
- Civil insurrection;
- Major disaster;
- Disability of a significant part of participating Hospital and practitioner Network;
- Epidemic; or
- Labor dispute not involving the Health Plan, participating Hospitals, and other Participating Providers.

Participating Providers will use their best efforts to provide Services and benefits within the limitations of available Facilities and personnel. However, neither the Health Plan, nor any Participating Provider shall have any liability or obligation because of a delay or failure to provide such Services or benefits. If the rendering of Services or benefits under this Individual Policy is delayed due to a labor dispute involving the Health Plan or Participating Providers, non-Emergency Care may be deferred until after the resolution of the labor dispute.

VIII. COMPLAINT, GRIEVANCE, AND APPEAL PROCEDURES

A Complaint is an informal expression of dissatisfaction related to benefits or Services provided under this Individual Policy. A Grievance is a formal Complaint regarding Service issues or the quality of care. An Appeal is a formal dispute regarding an Adverse Coverage Determination (denial of Coverage or application of Cost-Share). The Health Plan administers an informal Complaint procedure, a formal Grievance Procedure, and a formal Appeal procedure. All procedures take into account the urgency of the Covered Person's medical Condition.

THE INFORMAL COMPLAINT PROCEDURE

Many Complaints can be resolved by using the informal Complaint procedure, which consists of personal and informal discussion about the problem. The Covered Person or his/her authorized representative should contact the Customer Service Department at 1.855.443.4735 with any initial Complaint, and the Customer Service Representative will make every effort to resolve the problem. A formal Grievance may also be filed according to the procedure defined below, with assistance provided, if necessary.

GRIEVANCE PROCEDURES

Grievances related to Service issues or quality of care must be submitted within one (1) year of the event causing the Grievance. To file a written Grievance, the Covered Person or his/her authorized representative must submit a Grievance containing the following information:

- The Covered Person's name, address, and identification number;
- A summary of the concern, along with any supporting documentation/medical records;
- A description of relief sought;
- The Covered Person's or authorized representative's signature; and
- The date the Grievance is signed.

Formal Grievances may be sent to:

Mail: Health First Health Plans
ATTN: Appeals Coordinator
6450 U.S. Highway 1
Rockledge, FL 32955

Email: hfhpinfo@hf.org

Fax: 321.434.4769
ATTN: Appeals Coordinator

A verbal or written request for a fast (expedited) Grievance review is permitted and will be granted if:

- An extension has been invoked for making an initial Coverage determination or decision on an Appeal, and the Covered Person disagrees with the extension; or
- A request for an expedited initial Coverage decision or Appeal has not been granted, and the medication or Service has not been received.

To request a fast (expedited) Grievance review verbally, contact 1.855.443.4735, Monday through Friday 8 a.m. - 8 p.m. and Saturday through Sunday 9 a.m. - 5 p.m. For issues that qualify for the expedited process, a Health Care Provider with knowledge of the Covered Person's medical or behavioral health Condition (e.g., a treating Physician) may act as the Covered Person's representative without being appointed in writing.

The Health Plan will resolve a non-urgent Grievance and notify You or Your authorized representative within thirty (30) days after receipt of the Grievance. This resolution time frame may be extended up to fourteen (14) calendar days if the delay is necessary for a thorough investigation. In such cases, You or Your authorized representative will be notified in writing within the original thirty (30) day time frame of the delay and the reasons for it. If You do not agree to the extension, You or Your authorized representative may file an expedited Grievance.

Expedited Grievances will be resolved, and You or Your authorized representative will be notified, within seventy-two (72) hours after the Health Plan receives the Grievance. Expedited Grievances are not eligible for an extension of the resolution time frame. The Health Plan shall provide written confirmation of its decision concerning an expedited review within two (2) business days after providing notification of that decision, if the initial notification was not in writing.

Depending on the nature of the Grievance, Appeal rights may be available and will be communicated with the decision.

APPEAL PROCEDURE – GENERAL INFORMATION

If benefits are denied, in whole or in part, the Health Plan will provide the Covered Person or his/her authorized representative written notice of the denial. The denial notice will include:

- The reason for the denial;
- A reference to the benefit provision, guideline, or other criterion on which the decision was based, and notification that the actual provision, guideline, or criteria is available upon request;
- A description of Appeal rights, including the right to submit written comments, documents, or other information relevant to the Appeal;
- An explanation of the Appeal process, including the right to representation and time frames for deciding Appeals; and
- Information on the Expedited Appeal process.

For urgent medical situations, an Expedited Appeal procedure is available if applying the standard time frame would jeopardize the Covered Person's health or ability to regain maximum functioning. The Health Plan reserves the right to determine if the Covered Person's situation warrants the expedited process and will not expedite Appeals for Services that have already been received. Expedited Appeals may be filed verbally by contacting 1.855.443.4735, Monday through Friday 8 a.m. - 8 p.m. and Saturday through Sunday 9 a.m. - 5 p.m.

Appeal reviews will take into account all new information, regardless of whether the information was considered in the initial decision on the Claim.

The Covered Person or his/her authorized representative shall have the right to access, upon request and without charge, copies of all documents, records, and other information relevant to their Appeal.

APPEAL PROCEDURE – FIRST LEVEL OF REVIEW

SUBMITTING APPEALS

Appeals must be submitted within one (1) year of being notified of an Adverse Coverage Determination. To initiate the standard Appeal procedure, the Covered Person or their authorized representative should submit a written Appeal containing the information listed below. Expedited Appeals may be submitted verbally:

- The Covered Person's name, address, and identification number;
- A summary of the concern, along with any supporting documentation/medical records;
- A description of relief sought;
- The Covered Person's or authorized representative's signature; and
- The date the Appeal is signed.

Written Appeals may be sent to:

Mail: Health First Health Plans
ATTN: Appeals Coordinator
6450 U.S. Highway 1
Rockledge, FL 32955

Fax: 321.434.4769
ATTN: Appeals Coordinator

Email: hfhpinfo@hf.org

Expedited Appeals may be filed verbally by contacting 1.855.443.4735, Monday through Friday 8 a.m. - 8 p.m. and Saturday through Sunday 9 a.m. - 5 p.m.

FIRST LEVEL REVIEW TIME FRAMES

For standard pre-service Appeals, a decision will be made and written notification will be provided within fifteen (15) calendar days of receipt of the Appeal.

For standard post-service Appeals, a decision will be made and written notification will be provided within thirty (30) calendar days of receipt of the Appeal.

For Expedited Appeals, a decision will be made as quickly as the Covered Person's medical Condition requires, but in no longer than seventy-two (72) hours. Verbal notice of the decision will be provided within a seventy-two (72) hour time frame, with a written decision provided within three (3) days after the verbal notification.

Extensions: One (1) fourteen (14) day extension is permitted if additional information is necessary to make a decision on the Appeal, and the Covered Person or his/her authorized representative agrees to the extension.

AUTHORIZED REVIEWERS

Appeals related to non-medical issues will be reviewed by an appropriate person with problem-solving authority for a final decision. An individual who has made a previous decision on the case will not be involved with the decision upon review, nor will his or her subordinates.

If the Appeal involves an Adverse Determination based on Medical Necessity, a Physician with appropriate medical expertise will review the case and make a determination. A Physician who has made a previous decision on the case will not be involved with the decision upon review, nor will his or her subordinates.

EXTERNAL REVIEW

External review is available for Appeals that involve Medical Necessity or the determination of whether a Service is experimental or investigational. Within four (4) months after receiving a final determination from the Health Plan regarding an adverse outcome of an Appeal, a Covered Person or their authorized representative has the right to request external binding review. There is no dollar limit on issues eligible for review, nor any cost associated with this review.

If the Covered Person's medical Condition warrants an Expedited Appeal process (as determined by the Health Plan), expedited external review may be requested when an Expedited Appeal is requested through the Health Plan (at any level of Appeal), and after the internal Appeal process has been completed.

To request external review, the Covered Person or their authorized representative must contact the Health Plan by writing to the address or calling the number below:

Mail:	Health First Health Plans ATTN: Appeals Coordinator 6450 U.S. Highway 1 Rockledge, FL 32955	**Fax:**	321.434.4769 ATTN: Appeals Coordinator
Phone:	1.855.443.4735 1.800.955.8771 (TDD/TTY)	**Email:**	hfhpinfo@hf.org

For standard external review requests, the Health Plan will complete a preliminary review of the request to determine if the Appeal is eligible for external review within five (5) business days of receipt of the request. For Expedited Appeals (as determined by the Health Plan), this preliminary review will be conducted the same day the request is received.

ELIGIBILITY REQUIREMENTS FOR EXTERNAL REVIEW

An Adverse Coverage Determination is eligible for external review under the following circumstances:

- The request for external review is filed by You or Your authorized representative;
- The request is made in the required time frame, as indicated above;
- The request is made by the correct method (standard requests in writing);
- You must be (or must have been) Covered under the plan when the item or Service was requested (for pre-service Appeals) or when it was received (for post-service Appeals);
- The Adverse Coverage Determination does not relate to Your failure to meet the requirements for eligibility under the terms of this Individual Policy; and
- One (1) of the following has occurred:
    - The entire internal Appeal process has been completed;
    - The Health Plan deems the internal Appeal process completed; or
    - An Appeal meeting expedited criteria has been filed with the Health Plan.

If the request is incomplete, the notification will describe the information needed to complete the request, allowing for submission of the information within the original four (4) month filing period, or within forty-eight (48) hours after receipt of the notification, whichever is greater.

For Appeals eligible for external review, the Health Plan will assign the case to an Independent Review Organization ("IRO") accredited by a nationally recognized accrediting organization to conduct external review, ensuring against bias by rotating cases between at least three (3) IROs. The IRO will notify the Covered Person or his/her authorized representative in writing of the Appeal's acceptance for external review and of Your right to submit additional information. The

final decision will be issued within forty-five (45) days after receiving the request. For Expedited Appeals, the IRO will notify the Covered Person or their authorized representative of the decision as quickly as the individual's medical Condition requires, but in no later than seventy-two (72) hours after receiving the request. If the notification is made verbally, written notice will be provided within forty-eight (48) hours after the verbal notice.

ADDITIONAL ASSISTANCE WITH GRIEVANCES AND APPEALS

The Covered Person or his/her authorized representative has the right to contact, at any point throughout this process, the Florida Department of Financial Services.

Florida Department of Financial Services:

Department of Financial Services
Division of Consumer Services, 5th Floor
200 East Gaines Street
Tallahassee, Florida 32399-0327
1.877.693.5236
Email: Consumer.Services@myfloridacfo.com
Website: https://www.myfloridacfo.com/Division/Consumers/needourhelp.htm

You may contact AHCA for assistance with the submission of a Grievance or Appeal at any time during the Grievance process. The toll-free telephone number and the address for the Agency are:

Florida Agency for Health Care Administration:

Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308
Toll-free: 1.888.419.3456
Florida Relay Service (TDD number): 1.800.955.8771

IX. THE HEALTH PLAN'S PHARMACY PROGRAM

Coverage for Prescription Drugs and supplies is provided through the Health Plan's Pharmacy Program described in this section. We provide Coverage to You for Medically Necessary Prescription Drugs and supplies. The Health Plan maintains a Formulary, which is a list of Your approved medications. This Drug list is an extensive list of safe and effective, FDA-approved, Brand Name and Generic Prescription Drugs used to treat medical Conditions.

The Pharmacy and Therapeutics ("P&T") Committee, a panel of Physicians and pharmacists, develops Our Drug list and updates it regularly. The list includes quality Drugs available to You at reasonable cost. Only those medications that have successfully passed federally required clinical testing and evaluation and have been proven effective are included. The P&T Committee reviews and evaluates all available literature about a Drug when updating the list.

Formularies may be updated on a quarterly basis. Updates are reviewed by the pharmacists, Physicians, and other professionals on the P&T Committee to ensure that You have access to a broad range of Drugs at affordable prices. The Formulary is subject to change without notice. New versions are made available on the first day of any month in which a change will be effective.

For a current copy of Your Formulary or to get updated information about Covered Drugs, please visit Our web site, hf.org/healthplans.

Please note that before payment will be made for Covered Prescription Drugs and supplies, the applicable Calendar Year Prescription Drug Deductible must be satisfied. Once the Calendar Year Prescription Drug Deductible has been satisfied, You must pay, at the time of purchase, the applicable Copayment or Coinsurance Percentage of the Participating Pharmacy Allowance indicated on the Schedule of Benefits for each Prescription.

On the Formulary, You will find the following list of Drug Tiers:

- Tier 0 (Preventive Care Prescription Drugs);
- Tier 1 (Preferred Generic Prescription Drugs);
- Tier 2 (Non-Preferred Generic Prescription Drugs);
- Tier 3 (Preferred Brand Name Prescription Drugs);
- Tier 4 (Non-Preferred Brand Name Prescription Drugs); and
- Tier 5 (Specialty Drugs).

Multi-Source Brand Medications vs. Generic Medications ("Dispense as Written" ("DAW") Differential)

Multi-source brand medications are Brand Name Prescription Drugs with a generic available for that brand. If Your Physician writes a Prescription for You that is a multi-source brand name medication and a generic is available for that brand Drug, Your Prescription will be filled with the generic medication. However, if a multi-source Brand Name Prescription Drug is requested by You or Your Physician and filled, then You will pay the brand name Copayment plus the difference in the actual cost of the generic Drug and the Brand Name Prescription Drug. The brand name Copayment + Difference in cost between the generic and the brand is called a DAW Differential. The DAW Differential will be applied to all multi-source brand name medications.

You may be able to reduce Your out-of-pocket expenses by:

- Using Participating Pharmacies;
- Choosing Preferred Prescription Drugs rather than Non-Preferred Prescription Drugs; and
- Asking Your Physician to write for generic alternatives instead of Brand Name Prescription Drugs.

To verify if a Pharmacy is a Participating Pharmacy, You may access the Provider/Pharmacy Directory on Our website at hf.org/healthplans.

A. COVERED PRESCRIPTION DRUGS AND SUPPLIES

Covered Prescription Drugs and supplies are listed in the Formulary. Some Drugs require proof of Medical Necessity and prior approval by the Health Plan. Step therapy requirements and quantity limits may also apply.

All Prescription Drugs and supplies must be supplied by a Network Pharmacy in order to be Covered.

Covered Prescription Drugs and supplies may only be dispensed pursuant to a Prescription from a licensed prescriber. Specific OTC products or medications are Covered when prescribed by a health care professional and identified on the Formulary.

In the case of a Specialty Drug (Prescription Drugs that are identified as Specialty Drugs in the Formulary), Prior Authorization may be required. Specialty Drugs must be obtained at a specialty Pharmacy designated by the Health Plan.

B. COVERAGE AND BENEFIT GUIDELINES FOR COVERED PRESCRIPTION DRUGS AND SUPPLIES

In providing benefits under the Health Plan's Pharmacy Program, We may apply the benefit guidelines set forth below, as well as any other applicable payment rules specific to particular Covered Services listed in this Certificate.

A Covered Person may request medication synchronization to align the refill dates of their Prescription Drugs. These Prescriptions must be fulfilled at a Network Pharmacy. If You have any questions, please contact the Customer Service Department at 1.855.443.4735.

CONTRACEPTIVE COVERAGE

Oral, transdermal, intravaginal, and intramuscular contraceptives that are on the Formulary will be Covered under this Certificate. Due to the Preventive care provision of the ACA, some of these contraceptives will be available at no Cost-Share up to the ACA age limit. Refer to the current Formulary for an updated list. We reserve the right to add, remove, or reclassify any Prescription Drug in the Formulary at any time during the Calendar Year.

DIABETIC COVERAGE

All Covered Prescription Drugs and supplies listed on the Formulary that are used in the treatment of diabetes are Covered, subject to the limitations and exclusions listed in this Certificate. Insulin is only Covered if prescribed by a Physician or other Health Care Provider acting within the scope of his or her license.

The following supplies and equipment used in the treatment of diabetes are Covered under the Health Plan's Pharmacy Program, as listed on our Formulary:

- Blood glucose testing strips;
- Lancets;
- Blood glucose meters; and
- Syringes and needles prescribed in conjunction with insulin.

Please see the Formulary for approved products. Non-Formulary supplies require Prior Authorization.

Exclusion: All other supplies used in the treatment of diabetes, except those listed above as Covered, are excluded from Coverage under the Health Plan's Pharmacy Program.

MINERAL SUPPLEMENTS AND VITAMINS COVERAGE

All mineral supplements and vitamins are excluded from Coverage, except for prenatal vitamins and Preventive medications that are noted in the Formulary as Tier 0.

C. THE HEALTH PLAN'S PHARMACY PROGRAM LIMITATIONS AND EXCLUSIONS

Coverage and benefits for Covered Prescription Drugs and supplies are subject to the following limitations, in addition to all other provisions and exclusions in this Certificate:

- Any Prescription Drug or supply filled at an Out-of-Network Pharmacy is excluded from Coverage;
- Prescription Drugs and supplies prescribed by an Out-of-Network Provider whose Services are not pre-authorized by the Health Plan, are excluded from Coverage, except when prescribed by an emergency room or Urgent Care Physician in an emergency room or Urgent Care setting for an acute Condition;
- We will not Cover more than the maximum supply, as set forth in the Formulary, per Prescription for Covered Prescription Drugs and supplies;

- Prescription refills beyond the time limit specified by state and/or federal law are not Covered;
- Certain Prescription Drugs and supplies, as identified in the Formulary, have quantity limitations, or require Prior Authorization or step therapy in order to be Covered;
- Prescription Drugs and supplies not on the current Formulary are not Covered, unless authorized in advance by the Health Plan;
- Drugs that do not, by federal or state law, require a Prescription (i.e., OTC Drugs) are not Covered, except those required due to Preventive care provisions of the ACA (noted in the Formulary as Tier 0). A health care professional must prescribe Covered OTC products;
- Any legend Drug for which an OTC equivalent is available without a Prescription (i.e., Zyrtec) is excluded from Coverage;
- Any Drug labeled "Caution: Limited by federal law to investigational use" and experimental Drugs are not Covered;
- Any medication that is consumed or administered at the place it is dispensed, except Covered vaccinations listed on the Formulary, are excluded from Coverage;
- Drugs or biologics that, for safety purposes or otherwise, are typically administered via infusion or injection by a medical professional (not self-administered, like insulin or Imitrex) are not Covered under the Prescription Drug benefit unless otherwise noted in the Formulary or approved in advance by the Health Plan;
- Any injection medication that is not self-administered (i.e., IV administration, Medical Professional administration only, etc.) is excluded from Prescription Drug Coverage except as specifically provided for in the Covered Services section of this Certificate, unless approved by the Health Plan in advance;
- Cosmetics, or any Drugs and supplies used for cosmetic purposes (such as Retin-A, Rogaine, Topical Minoxidil, Vaniqa, etc.), are excluded from Coverage;
- Drugs or supplies when used for the treatment of sexual dysfunction or erectile dysfunction are not Covered;
- Drugs and supplies for which the Covered Person is not charged are excluded from Coverage;
- Drugs or supplies when used for the treatment of infertility (such as Clomid) are not Covered;
- Replacement, or early refills, of lost, damaged, or stolen Prescription Drugs or supplies are excluded from Coverage, except when authorized in advance by the Health Plan;
- Support garments are not Covered;
- Syringes, needles, or other disposable supplies (except those used with insulin) are not Covered;
- All new Drugs approved by the FDA will be excluded from the Formulary, unless the P&T Committee, in its sole discretion, decides to waive this exclusion with respect to a particular Drug;
- Any Drug or supply dispensed prior to the Effective Date or after the termination date of Coverage for this Certificate is not Covered;
- Therapeutic devices, appliances, medical, or other supplies and equipment (e.g., air and water purifiers, support garments, creams, gels, oils, and waxes), regardless of the intended use (except for Covered Prescription supplies) are excluded from Coverage;
- Multivitamins and nutritional supplements are excluded from Coverage, except Prescription prenatal vitamins and those required due to Preventive care provisions of the ACA (noted in the Formulary as Tier 0);
- Tiering exceptions to the assigned Tier for a medication on the Formulary or given Tier for Non-Formulary medications are excluded;

- Prescription Drugs and supplies for which benefits are paid under Workers' Compensation coverage or any other similar law, whether benefits are payable for all or only part of the charges, are not Covered;
- Prescription Drugs and supplies for procedures and Services that are not Covered are excluded from Coverage;
- Refills in excess of the amount specified by the Participating Physician, refills filled before eighty-five percent (85%) of the Prescription has been used (ninety percent (90%) for controlled substances), or any refill dispensed after one (1) year from the order of the Physician are excluded from Coverage. Additionally, early fills that provide greater than a ninety (90) day supply of any one (1) Prescription Drug are excluded from Coverage;
- Drugs and supplies purchased from any source (including a Pharmacy) outside of the United States are excluded from Coverage. This includes Drugs or supplies prescribed by any health care professional not licensed in any state or territory (e.g., Puerto Rico, U.S. Virgin Islands, or Guam) of the United States;
- Drugs specifically used for reducing or controlling weight are not Covered;
- Drugs used to treat dental Conditions, periodontitis, and/or periodontal disease are excluded from Coverage;
- Biological sera, blood, and blood plasma products are excluded from Coverage;
- Drugs not approved by the FDA under the Federal Food, Drug, and Cosmetic Law and Regulations are excluded from Coverage;
- Drugs prescribed for uses or indications other than the FDA approved label indications are excluded. This exclusion does not apply if approved through the Prior Authorization process;
- Drugs that do not have a valid National Drug Code ("NDC") are excluded from Coverage;
- Any Drug prescribed in excess of the manufacturer's recommended specifications for dosages, frequency of use, or duration of administration as set forth in the manufacturer's insert for such Drug. This exclusion does not apply if We, in Our sole discretion, waive this exclusion with respect to a particular Drug or therapeutic classes of Drugs;
- Any benefit penalty reductions or any charges in excess of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance are excluded from Coverage;
- Self-prescribed Drugs or supplies and Drugs or supplies prescribed by or supplied by any person related to You by blood, marriage, Adoption, or Domestic Partnership are excluded from Coverage;
- Food or medical food products, whether prescribed or not, are excluded from Coverage;
- Acthar (corticotropin, repository) is excluded from Coverage except for in the use of infantile spasms in infants and children under two (2) years of age;
- Drugs purchased using a coupon or discount card, other than PAPs when applicable, will not be Covered;
- Allergy Serums are not Covered as a Pharmacy Benefit;
- Growth hormone therapy used to treat familial short stature is not Covered. This exclusion does not apply to growth hormone therapy when determined Medically Necessary to treat a medical Condition other than familial short stature;
- Vitamin B-12 injections are not Covered except for the treatment of pernicious anemia when oral vitamin B cannot be absorbed. These injections are subject to a Medical Necessity review;
- Compounded Drugs are not Covered unless the compounded Drug contains at least one (1) ingredient that has been approved by the FDA. Compounded Drugs that are available as a similar commercially available Prescription Drug are also not Covered. All compounded Drugs are subject to a Medical Necessity review;

- Prescription Drug compounding kits sent to You to be mixed at home (i.e., foot-baths) or Services provided to You related to the kits are not Covered. This does not include Drug compounds made and dispensed at a Pharmacy;
- Drugs obtained in an unauthorized manner (i.e., fraudulent identification) or Drugs for which the intended use would be illegal, unethical, or otherwise improper, are not Covered. This includes Drugs that have been repackaged by anyone other than the original manufacturer;
- Drugs dispensed in a medical office, Hospital, acute care, or long-term Facility for which the office or Facility is also seeking reimbursement from Your medical benefit or for which they receive a standard daily rate for inclusive Services are not Covered; and
- Prescription Drugs, Supplies, or devices provided in connection with an occupational sickness or an injury sustained in the scope of employment are not Covered.

COVERAGE FOR DRUGS NOT ON YOUR FORMULARY

Certain medications must be reviewed for Medical Necessity to determine if they are eligible for Coverage. Certain Drugs are not Covered by Your Individual Policy. Talk to Your prescriber about whether there are generic, OTC, or less expensive Drugs that could work just as well as the ones You are taking now. You, Your authorized representative, or Your prescribing Physician, may request to gain access to clinically appropriate Drugs not otherwise Covered by the Health Plan (a request for exception) if You and Your prescriber believe You need a Drug that is not on Your Formulary and is not excluded by Your Individual Policy.

When a request for exception is approved by the Health Plan, Your Cost-Share will vary depending on the cost of the Drug.

To request an exception, You may call Our Customer Service Department toll-free Monday through Friday, 8 a.m. – 6 p.m.

Toll-Free: 1.855.443.4735
Local: 321.434.5665
TDD/TTY: 1.800.955.8771

Your prescribing Physician may also submit an exception request form to 1.855.328.0061.

This form is available on Our website at hf.org/healthplans.

Standard Exception Request
The Health Plan will notify the Covered Person or the Covered Person's authorized representative and the prescribing Physician (or other prescriber, as appropriate) of its Coverage determination no later than seventy-two (72) hours following receipt of the request. If the Health Plan grants a standard exception request, Coverage of the non-Formulary Drug will be provided for the duration of the Prescription, including refills.

Expedited Exception Request
The Health Plan will make its Coverage determination on an expedited review request based on urgent circumstances and the Covered Person or the Covered Person's authorized representative and the prescribing Physician (or other prescriber, as appropriate) of its Coverage determination no later than twenty-four (24) hours following receipt of the request. If an exception based on Exigent Circumstances is granted, the Health Plan will provide Coverage of the non-Formulary Drug for the duration of the exigency. Exigent circumstances occur when a Covered Person is suffering from a health Condition that may seriously jeopardize the Covered Person's life, health, or ability to regain maximum function or when a Covered Person is undergoing a current course of treatment using a non-Formulary Drug.

External Exception Request Review

If the Health Plan denies a request for a standard exception or for an expedited exception, the Covered Person, the Covered Person's authorized representative, or the prescribing Physician, can request that the original exception request and subsequent denial of such request be reviewed by an IRO.

The Health Plan will make its determination on the external exception request and notify the Covered Person or the Covered Person's authorized representative and the prescribing Physician (or other prescriber, as appropriate) of its Coverage determination, no later than:

- Seventy-two (72) hours following its receipt of the request, if the original request was standard; and
- Twenty-four (24) hours following its receipt of the request, if the original request was expedited.

If the Health Plan grants an external exception review of a standard exception request, Coverage of the non-Formulary Drug will be for the duration of the Prescription. If the Health Plan grants an external exception review of an expedited exception request, Coverage of the non-Formulary Drug will be for the duration of the exigency.

D. PAYMENT RULES

Under the Health Plan's Pharmacy Program, the amount You must pay for Covered Prescription Drugs and supplies may vary depending on:

- The participation status of the Pharmacy where purchased (i.e., Participating Pharmacy versus Non-Participating Pharmacy);
- The terms of Our agreement with the Pharmacy selected;
- Whether You have satisfied the Calendar Year Prescription Drug Deductible and/or any amount You are required to pay, as set forth in the Schedule of Benefits;
- Whether the Prescription Drug is a Generic Prescription Drug or a Brand Name Prescription Drug;
- Whether the Prescription Drug is in the Preferred Formulary tier;
- Whether the Prescription Drug is purchased from the Mail Order Pharmacy; and
- If the Prescription is a multi-source brand name Drug that has a generic available, a DAW Differential may be added to the cost of the Prescription.

We reserve the right to add or reclassify any Prescription Drug in the Formulary at any time during the Calendar Year.

E. PHARMACY ALTERNATIVES

For purposes of this section, there are three (3) types of Pharmacies: Participating Pharmacies, Mail Order Pharmacies, and Non-Participating Pharmacies.

PARTICIPATING PHARMACIES

Participating Pharmacies are Pharmacies participating in the Health Plan's Pharmacy Network at the time You purchase Covered Prescription Drugs and supplies. Participating Pharmacies have agreed not to charge, or collect from You, for each Covered Prescription Drug and Covered Prescription supply, more than the amount set forth in the Schedule of Benefits. In the Health Plan's Pharmacy Program, there are two (2) types of Participating Pharmacies:

- Pharmacies within Our Network that have signed a Participating Pharmacy Provider agreement with Us; and
- The Mail Order Pharmacy.

To verify if a Pharmacy is a Participating Pharmacy, You may access the Provider/Pharmacy Directory on Our website at hf.org/healthplans.

Prior to purchase, You must present Your ID card to the Participating Pharmacy. The Participating Pharmacy must be able to verify that We, in fact, Cover You.

Charges for Covered Prescription Drugs and supplies by a Participating Pharmacy will depend on the agreement then in effect between the Pharmacy and Us.

MAIL ORDER PHARMACY

A Mail Order Pharmacy is a Pharmacy that has signed a Mail Services Prescription Drug agreement with Us. For additional details on how to obtain Covered Prescription Drugs and supplies from the Mail Order Pharmacy, please refer to the Provider/Pharmacy Directory, or go to hf.org/healthplans for specifics.

NON-PARTICIPATING PHARMACIES

For additional information regarding Coverage for Non-Participating Pharmacies, please see **The Health Plan's Pharmacy Program Limitations and Exclusions** section and the **How to File a Claim for Benefits** section.

F. PHARMACY UTILIZATION REVIEW PROGRAMS

Our Pharmacy utilization review programs are intended to encourage the responsible use of Prescription Drugs and supplies. We may, at Our sole discretion, require that Prescriptions for select Prescription Drugs and supplies be reviewed under Our Pharmacy utilization review programs, then in effect, in order for there to be Coverage for them. Under these programs, there may be limitations or conditions on Coverage for select Prescription Drugs and supplies, depending on the quantity, frequency, or type of Prescription Drug.

Note: If Coverage is not available, or is limited, this does not mean that You cannot obtain the Prescription Drug or supply from the Pharmacy. It only means that We will not Cover or pay for the Prescription Drug or supply. You are always free to purchase the Prescription Drug or supply at Your sole expense.

Our Pharmacy utilization review programs include the following:

STEP-THERAPY

Under this program, We may exclude from Coverage certain Prescription Drugs unless You have first tried designated Drug(s) identified in the Formulary in the order indicated. In order for there to be Coverage for such Prescription Drugs prescribed by Your Physician, We must receive written attestation and medical records confirming that the pre-requisite Drugs are not appropriate for You because of a documented allergy, ineffectiveness, or side effect.

Prior to filling Your Prescription, Your Physician may, but is not required to, contact Us to request Coverage for a Prescription Drug subject to the Step-Therapy program by following the procedures for Prior Authorization outlined in the Formulary.

DOSE OPTIMIZATION (QUANTITY LIMITS) PROGRAM

For certain Drugs, We limit the amount of the Drug that You can have by limiting how much of a Drug You can get each time You fill your Prescription. Under this program, any Prescription Drug prescribed in excess of the maximum limitation noted in the Formulary is not Covered, unless authorized in advance by the Health Plan.

PRIOR AUTHORIZATION PROGRAM

You are required to obtain Prior Authorization from Us in order for certain Prescription Drugs and supplies to be Covered. Failure to obtain Authorization will result in denial of Coverage. Prescription Drugs and supplies requiring Prior Authorization are designated in the Formulary.

For additional details on how to obtain Prior Authorization, refer to the Formulary. Information on Our Pharmacy utilization review programs is published in the Formulary at hf.org/healthplans. Your pharmacist may also advise You if a Prescription Drug requires Prior Authorization.

G. ULTIMATE RESPONSIBILITY FOR MEDICAL DECISIONS

The Pharmacy utilization review programs have been established to determine whether Coverage or benefits for Prescription Drugs and supplies will be provided under the applicable terms of this Certificate. Ultimately, the final decision concerning whether a Prescription Drug should be prescribed must be made by You and Your prescribing Physician. Decisions made by Us in authorizing Coverage are made only to determine whether Coverage or benefits are available under this Certificate and not for the purpose of providing or recommending care or treatment. We reserve the right to modify or terminate these programs at any time.

Any and all decisions that require or pertain to independent professional medical judgment or training or the need for a Prescription Drug or supply must be made solely by You and Your treating Physician in accordance with the patient/Physician relationship. It is possible that You or Your treating Physician may conclude that a particular Prescription Drug or supply is needed, appropriate, or desirable, even though such Prescription Drug or supply may not be authorized for Coverage by Us. In such cases, it is Your right and responsibility to decide whether the Prescription Drug or supply should be purchased, even if We have indicated that Coverage and payment will not be made for such Prescription Drug or supply.

X. PEDIATRIC DENTAL BENEFITS

Coverage for Pediatric Dental Benefits is provided for the Services described in this Certificate, for a Covered Person up to the end of the birth month in which the Covered Person reaches the age of nineteen (19). Participating Provider Claims for Covered Services will be paid, less any applicable Cost-Share. The Health Plan contracts with a third party dental Provider to offer pediatric dental Services, classified as essential health benefits, for any Covered Person who meets and continues to meet the eligibility requirements specified in this Certificate. To view plan details, visit hf.org/healthplans or contact the dental Customer Service Center at 1.877.873.0732.

Pediatric dental Services are provided through a Network of Participating Dental Providers. This Network is composed of established dental professionals. There are no lifetime maximums or Claim forms when You visit a Participating Dental Provider. Covered Services are performed as deemed appropriate by Your attending Participating Dental Provider.

In the event a Participating Dental Provider is not paid for a Service, You will not be liable to that Participating Dental Provider for any sums owed by the third party dental Provider. If You have not received Authorization for treatment from an Out-of-Network Dental Provider, You may be liable to that Out-of-Network Dental Provider for the cost of Services. For further clarification, please see “Dental Emergency Services” and “Dental Specialist Services” under this section.

HOW TO USE THE PEDIATRIC DENTAL BENEFITS

Upon enrollment, an eligible Covered Person may contact any Participating Dental Provider. A list of Participating Dental Providers is available to the Covered Person at hf.org/healthplans.

All dental treatment in progress must be completed before You change to another Participating Dental Provider. For example, this would include:

- Partial or full dentures for which final impressions have been taken;
- Completion of root canals in progress; and
- Delivery of crowns when teeth have been prepared.

All Covered Services shall be rendered at the Participating Dental Provider. There is no obligation or liability with respect to Services rendered by Out-of-Network Dental Providers, with the exception of Dental Emergency Services or Dental Specialist Services recommended by a Participating Dental Provider, or Services that have been authorized.

All authorized Dental Specialist Services Claims will be paid, less any applicable Cost-Share. A Participating Dental Provider may provide Covered Services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the Services. For additional information, please reference Your dental plan documents.

If Your Participating Dental Provider terminates participation in the plan, that Participating Dental Provider will complete all treatment in progress as described above.

DENTAL EMERGENCY SERVICES

Participating Dental Providers maintain a twenty-four (24) hour Dental Emergency Services system, seven (7) days a week. If Dental Emergency Services are needed, You should contact the Participating Dental Provider whenever possible. If You are unable to reach the Participating Dental Provider for Dental Emergency Services, You should call the dental Customer Service Center at 1.877.873.0732 for assistance in obtaining Emergency Care.

During non-business hours or if You require Dental Emergency Services and are thirty-five (35) miles or more from Your Participating Dental Provider, You do not need to call for referral and may seek treatment from a Dentist other than at the Participating Dental Provider. You are responsible for the Cost-Share for any treatment received due to an emergency. Emergency dental care is limited to palliative treatment for the elimination of dental pain. Further treatment must be obtained from the Participating Dental Provider.

DENTAL SPECIALIST SERVICES

Dental Specialist Services for major Services must be: 1) referred by Your Participating Dental Provider; and 2) be pre-authorized.

If You require Dental Specialist Services and there is no participating dental specialist to provide these Services within thirty-five (35) miles of Your home address, Your Participating Dental Provider must receive Authorization to refer You to an Out-of-Network Dental Provider to provide the Dental Specialist Services. Dental Specialist Services performed by an Out-of-Network Dental Provider that are not authorized, may not be Covered.

CLAIMS FOR REIMBURSEMENT

Claims for Covered Dental Emergency Services or authorized Dental Specialist Services should be sent within ninety (90) days of the end of treatment. Valid Claims received after the ninety (90) day period, will be reviewed if You can show that it was not reasonably possible to submit the Claim within that time. All Claims must be received within one (1) year of the treatment date.

Claims for Pediatric Dental Services must be sent to:

LIBERTY Dental Plan
Attention: Claims
PO Box 26110
Santa Ana, CA 92799-6110

DENTAL GRIEVANCES AND APPEALS

You will be provided notification if any pediatric dental Services or Claims are denied, in whole or in part, stating the specific reason or reasons for the denial. Grievances regarding eligibility, the denial of pediatric dental Services or Claims, the policies, procedures or operations with regard to Pediatric Dental Benefits or the quality of pediatric dental Services performed by a Participating Dental Provider, You may call the dental Customer Service Center at 1.855.443.4735 or the Grievance may be addressed in writing to:

Health First Health Plans
ATTN: Appeals Coordinator
6450 U.S. Highway 1
Rockledge, FL 32955

Written communication must include:

- The name of the Covered Person;
- The name, address, telephone number, and ID number of the Covered Person; and
- The Dentist's name and Facility location.

Within ten (10) business days of the receipt of any Grievance, the Dental Quality Management Coordinator will forward to You an acknowledgment of receipt of the Grievance. Certain Grievances may require that You be referred to a Dentist for clinical evaluation of the pediatric dental Services provided. A determination of Your Grievance will be sent to You, in writing, within thirty (30) days of receipt of a Grievance or You will be provided a written explanation if additional time is required to report on the Grievance.

A full and fair review of the decision shall be undertaken if a written request for an Appeal of the determination is made within thirty (30) days of the date of the written determination. A response to Your Appeal shall be provided in writing within thirty (30) days after receipt of the Appeal and supporting documentation or a written explanation will be provided to You if additional time is required to issue the results.

PEDIATRIC VISION BENEFITS

Coverage for Pediatric Vision Benefits is provided for the Services described in this Certificate, for a Covered Person up to the end of the birth month in which the Covered Person reaches nineteen (19) years of age. Participating Provider Claims for Covered Services will be paid, less any applicable Cost-Share. The Health Plan contracts with a third-party vision Provider to offer pediatric vision Services, classified as essential health benefits, for any Covered Person who meets, and continues to meet, the eligibility requirements specified in this Certificate. To view plan details, visit www.davisvision.com or contact the vision Customer Service Center at 1.800.999.5431.

Pediatric vision Services are provided through a Network of Participating Vision Providers. This Network is composed of established vision professionals. There are no lifetime maximums or Claim forms when You visit a Participating Vision Provider. Covered Services are performed as deemed appropriate by Your attending Participating Vision Provider.

HOW TO USE THE PEDIATRIC VISION BENEFITS

Upon enrollment, an eligible Covered Person may contact any Participating Vision Provider. A list of Participating Vision Providers is available to the Covered Person at www.davisvision.com.

All Covered Services shall be rendered at the Participating Vision Provider. There is no obligation or liability with respect to Services rendered by Out-of-Network Vision Providers, with the exception of Services that have been authorized.

CLAIMS FOR REIMBURSEMENT

Claims for authorized vision Specialist Services should be sent within ninety (90) days of the end of treatment. Valid Claims received after the ninety (90) day period, will be reviewed if You can show that it was not reasonably possible to submit the Claim within that time. All Claims must be received within one (1) year of the treatment date.

Claims for Pediatric Vision Services must be sent to:

Vision Care Processing Unit
PO BOX 1525
Latham, NY 12110

VISION GRIEVANCES AND APPEALS

You will be provided notification if any pediatric vision Services or Claims are denied, in whole or in part, stating the specific reason or reasons for the denial. For Grievances regarding eligibility, the denial of pediatric vision Services or Claims, the policies, procedures or operations with regard to Pediatric Vision Benefits, or the quality of pediatric vision Services performed by a Participating Vision Provider, You may call the vision Customer Service Center at 1.855.443.4735, or the Grievance may be addressed in writing to:

Health First Health Plans
ATTN: Appeals Coordinator
6450 U.S. Highway 1
Rockledge, FL 32955

Written communication must include:

- The name of the Covered Person;
- The name, address, telephone number, and ID number of the Covered Person; and
- The vision provider's name and Facility location.

Within ten (10) business days of the receipt of any Grievance, the Vision Quality Management Coordinator will forward to You an acknowledgment of receipt of the Grievance. Certain Grievances may require that You be referred to a vision Provider for clinical evaluation of the pediatric vision Services provided. A determination of Your Grievance will be sent to You, in writing, within thirty (30) days of receipt of a Grievance or You will be provided a written explanation if additional time is required to report on the Grievance.

A full and fair review of the decision shall be undertaken if a written request for an Appeal of the determination is made within thirty (30) days of the date of the written determination. A response to Your Appeal shall be provided in writing within thirty (30) days after receipt of the Appeal and supporting documentation or a written explanation will be provided to You if additional time is required to issue the results.

XI. DEFINITIONS

This section defines many of the terms used in this Certificate. Defined terms are capitalized and have the meanings set forth in this section. Additionally, certain important terms and phrases, not appearing in this section, which describe aspects of this Certificate, may be capitalized.

ACCIDENT or ACCIDENTAL means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic Injury. This term does not include Injuries caused by surgery or treatment for disease or illness.

ACCIDENTAL DENTAL INJURY means an Injury to Sound Natural Teeth (not previously comprised by decay) caused by a sudden, unintentional, and unexpected event or force. The term does not include Injuries to the mouth, structures within the oral cavity, or Injuries to natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

ADOPTION or ADOPT(ED) means the process and act of creating a legal parent/child relationship declaring that the child is legally the child of the adoptive parents and their heir-at-law and entitled to all the rights and privileges and subject to all the obligations of a child born to such adoptive parents, or as otherwise defined by Florida law, or similar applicable laws of another state.

ADVANCE PREMIUM TAX CREDIT ("APTC") means a tax credit that can help You afford Coverage purchased through the Marketplace. Sometimes known as APTC, "advance payments of the Premium tax credit," or "Premium tax credit". Unlike tax credits You claim when You file Your taxes, these tax credits can be used right away to lower Your monthly Premium costs. If You qualify, You may choose how much advance credit payments to apply to Your Premiums each month, up to a maximum amount. If the amount of advance credit payments You get for the year is less than the tax credit You are due, You will get the difference as a refundable credit when You file Your federal income tax return. If Your advance payments for the year are more than the amount of Your credit, You must repay the excess advance payments with Your tax return.

ADVERSE DETERMINATION or ADVERSE COVERAGE DETERMINATION means a Coverage determination by the Health Plan that an admission, availability or care, continued stay, or other medical Services have been reviewed and, based upon the information provided, does not meet the Health Plan's requirements for Medical Necessity, appropriateness, health care setting, or level of care for effectiveness. Coverage for the requested Service is therefore denied, excluded, reduced, or terminated.

AFFORDABLE CARE ACT ("ACA") means the comprehensive health care reform law enacted in March 2010. The law was enacted in two (2) parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" or "ACA" is used to refer to the final, amended version of the law.

ALLOWANCE, ALLOWABLE or ALLOWED AMOUNT means the maximum amount on which payment will be based for Covered Services. The Allowed Amount may be changed at any time without prior notice or consent of the Covered Person.

- In the case of an In-Network Provider located within the Service Area, this amount will be established in accordance with the applicable agreement between that Provider and the Health Plan.
- In the case of an In-Network Provider located outside of the Service Area, this amount will generally be established in accordance with the negotiated price that has been established between that Provider and the Health Plan.
- In the case of an Out-of-Network Provider that has not entered into an agreement with the Health Plan to provide access at a discount from the Provider's Billed Charges for the specific Covered Services provided to Covered Persons, the Allowed Amount will be the lesser of that Provider's actual billed amount for the specific Covered Services or an amount established by the Health Plan that may be based on several factors, including:
    - Payment for such Services under the Medicare program;

- Payment often accepted for such Services by that Out-of-Network Provider and/or by other Providers, either in Florida or in other comparable markets, that the Health Plan determines are comparable to the Out-of-Network Provider that provided the specific Covered Services (which may include payment accepted by such Out-of-Network Provider and/or by other Providers as Participating Providers in other Provider Networks of third-party payers which may include, for example, other insurance companies and/or HMOs);
- Payment amounts which are consistent, as determined by the Health Plan, with the Health Plan's Provider Network strategies (e.g., does not result in payment that encourages Providers participating in the Health Plan Network to become Non-Participating); and/or
- The cost of providing the specific Covered Services.

If a particular Covered Service is not available from any Provider that is in the Health Plan's Network, as determined by Us, the Allowed Amount means the usual and customary charge(s) of similar Providers in a geographical area established by Us.

You may obtain an estimate of the Allowed Amount for particular Services by calling the Customer Service Department phone number included in this Certificate or on Your ID card. The fact that We may provide You with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in this Certificate apply. You should refer to the **Covered Services** section of this Certificate and Your Schedule of Benefits to determine what is Covered and how much We will pay.

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with the Health Plan to provide access at a discount from the billed amount of that Provider, the Allowed Amount for particular Services is often substantially below the amount billed by such Out-of-Network Provider for such Services.

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

AMBULATORY SURGICAL CENTER means a Facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or other state's applicable law, of which the primary purpose is to provide elective surgical care to a patient, admitted to and discharged from such Facility within the same working day and which is not part of a Hospital.

APPEAL means a formal dispute regarding an Adverse Coverage Determination (denial of Coverage or application of Cost-Share).

APPLICANT means the person or persons who are petitioning the Health Plan for Coverage under this Individual Policy.

APPLIED BEHAVIOR ANALYSIS ("ABA") means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

ARTIFICIAL INSEMINATION ("AI") means a medical procedure in which sperm is placed into the female reproductive tract by a qualified Health Care Provider for the purpose of producing a pregnancy.

BALANCE BILL(ING) means when a Participating Provider bills a Covered Person for fees and surcharges above and beyond a Covered Person's Cost-Share for Covered Services or denied Claims.

BARIATRIC SURGERY means surgery to treat obesity, which includes procedures such as gastric banding and gastric bypass.

BENEFIT YEAR means a year of benefits Coverage under an individual health insurance plan. The Benefit Year for plans purchased inside or outside the Marketplace begins January 1st of each year and ends December 31st of the same year. Your Coverage ends December 31st, even if Your Coverage started after January 1st. Any changes to benefits or rates to a health insurance plan are made at the beginning of the Benefit Year.

BILLED CHARGES means the dollar amount billed by a Provider for treatment, Services, or supplies rendered.

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

BLOODLESS SURGERY means a surgical procedure requested by a Covered Person or a Covered Person's authorized representative for a Covered Person who refuses a blood transfusion even though such transfusion may be Medically Necessary due to blood loss during the intra-operative or post-operative period. The surgical procedure uses techniques to avoid blood transfusions.

BONE MARROW TRANSPLANT means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy and non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous Transplant or an allogeneic Transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving Bone Marrow Transplantation, the term "Bone Marrow Transplant" includes both the transplantation, and the administration of chemotherapy and the chemotherapy Drugs. The term "Bone Marrow Transplant" also includes any Services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician, or other Health Care Provider Services or supplies which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., Hospital room and board and ancillary Services).

BRAND NAME PRESCRIPTION DRUG means a Prescription Drug which is marketed or sold by a manufacturer using a trademark or proprietary name, an original or pioneer Drug, or a Drug that is licensed to another company by the Brand Name Prescription Drug manufacturer for distribution or sale, whether or not the other company markets the Drug under a generic or other non-proprietary name.

BRCA ANALYSIS means a genetic test to identify mutations in breast cancer susceptibility genes BRCA1 and BRCA2.

CALENDAR YEAR means the twelve-month period beginning January 1st and ending December 31st of the same year.

CARDIAC THERAPY means Health Care Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal health function in connection with myocardial infraction, coronary occlusion, or coronary bypass surgery.

CATASTROPHIC HEALTH PLAN means a health plan that meets all of the requirements under the ACA, including Coverage of the essential health benefits, but that does not cover any benefits other than three (3) primary care visits per year before the Deductible is met. The Premium for a Catastrophic Health Plan is generally lower than other Qualified Health Plans ("QHPs"); however, the out-of-pocket costs for Deductibles, Copayments, and Coinsurance are generally higher. To qualify for a Catastrophic Health Plan, You must be under thirty (30) years old OR get a "hardship exemption" because the Marketplace determined that You are unable to afford health coverage.

CERTIFICATE OF COVERAGE or CERTIFICATE means the document outlining Your specific plan and benefits and Coverage provisions, including exclusions and limitations. The Certificate includes the enrollment application, evidence of insurability, and any attached amendments.

CERTIFIED NURSE MIDWIFE means a person who is licensed pursuant to Chapter 464 of the Florida Statutes, or similar applicable laws of another state, as an APRN and who is certified to practice midwifery by the American College of Nurse Midwives.

CERTIFIED REGISTERED NURSE ANESTHETIST means a person who is a properly licensed advanced practice Registered Nurse within the nurse anesthetist category pursuant to the Florida Statutes, or similar applicable laws of another state.

CHIMERIC ANTIGEN RECEPTOR, T CELL ("CAR-T") THERAPY is a treatment modality for certain types of malignancies. This process consists of extracting a patient's own T cells, engineering them in-vitro to now express a receptor on the cell surface that can bind to the patient's tumor cells, and then infusing the engineered T cells back into the patient. When the engineered T cells bind to the specific tumor antigen on the patient's tumor cells, the T cells get activated. These activated T cells can now mount an immune response against the tumor cells.

CLAIM(S) means any request for a plan benefit or benefits made in accordance with the **Claim Provisions** section of this Certificate.

COINSURANCE or COINSURANCE PERCENTAGE means the sharing of Covered health care expenses between the Health Plan and You, as specifically set forth in the Schedule of Benefits, if applicable. Coinsurance is expressed as a percentage rather than as a flat dollar amount. After Your Calendar Year Deductible requirement is met, We will pay a percentage of the Allowed Amount for Covered Services, as listed in Your Schedule of Benefits.

COMPLAINT means any informal expression of dissatisfaction by a Covered Person, including dissatisfaction with the administration, Claims practices, a provision of Services, or quality of care provided by a Provider pursuant to the Certificate and which is submitted to the Health Plan or to a state agency. A Complaint is part of the informal steps of a Grievance Procedure.

CONCURRENT CARE CLAIM means an occurrence where the Health Plan has approved an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two (2) types of Concurrent Care Claims: (1) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and (2) where an extension is requested beyond the initially approved period of time or number of treatments.

CONDITION(S) means any Sickness, illness, disease, ailment, disorder, infection, Injury, complications of pregnancy, or bodily dysfunction of a Covered Person.

CONFINEMENT means an approved Medically Necessary Covered stay as an Inpatient in a Hospital that is:

- Due to a Covered Condition, and
- Authorized by a licensed medical Health Care Provider with admission privileges.

Each "day" of Confinement includes an overnight stay for which a charge is customarily made.

CONTRACTED RATE means the dollar amount the Health Plan has negotiated with Participating Providers for Covered Services and supplies. Insured are not responsible for any dollar amount a Participating Provider charges in excess of this negotiated fee schedule.

COPAYMENT means the specific dollar amount that the Covered Person must pay upon receipt of a Covered Service or at the time a Prescription Drug is obtained from a Pharmacy. Copayment amounts, if applicable, are set forth in the Schedule of Benefits and any Amendment attached to this Certificate. Certain Covered Services and Prescription Drugs are subject to the Calendar Year Deductible prior to the Copayment applying.

COSMETIC SURGERY means any non-Medically Necessary surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an Accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes Services such as ear-piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedure (e.g., mammoplasty, liposuction, keloids, rhinoplasty, and associated surgery), or treatment relating to the consequences or as a result of Cosmetic Surgery.

COST-SHARE or COST-SHARING means the amount of the Covered Person's financial responsibility as specifically set forth in the Schedule of Benefits and any Amendment attached to this Certificate. Cost-Share may include any applicable combination of Deductibles, Coinsurance, and Copayments, up to the Out-of-Pocket Maximum Expense Limit.

COVER, COVERED, or COVERAGE means inclusion of an individual for payment of expenses related to Covered Services under this Certificate.

COVERED DEPENDENT(S) means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually Covered, under the Individual Policy other than as the Insured. See the **Eligibility** section of this Certificate for more information.

COVERED PERSON(S) means an Insured and any Covered Dependent(s).

COVERED PRESCRIPTION DRUG means a Drug, which, under federal or state law, requires a Prescription and which is Covered under the Health Plan's Pharmacy Program.

COVERED SERVICE(S) or SERVICES means those Medically Necessary Services and supplies described in the **Covered Services** section of this Certificate and any attached Amendments.

CREDITABLE COVERAGE means health insurance coverage which is continuous to a date within sixty-two (62) days of Your Enrollment Date. Such health insurance coverage may include any of the following:

- A group health plan;
- Individual health insurance;
- Student health insurance;
- Medicare;
- Medicaid;
- CHAMPUS and TRICARE;
- The Federal Employees Health Benefits Program;
- A medical care program of the Indian Health Service;
- A state health insurance high risk pool;
- A health benefit plan of the Peace Corps;
- Children's Health Insurance Program ("CHIP"); or

- Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country).

CUSTODIAL CARE means non-Medically Necessary care that the Health Plan determines to be provided primarily for the maintenance of a Covered Person or is designed essentially to assist a Covered Person in meeting his or her activities of daily living and which is not primarily for its therapeutic value in the treatment of a Sickness or bodily Injury. Activities of daily living include bathing, feeding, dressing, walking, and taking oral medicine.

DEDUCTIBLE means the amount of charges, up to the Allowed Amount, for Covered Services or Prescription Drugs, which the Covered Person must actually pay each Calendar Year to an appropriately licensed Health Care Provider before the Health Plan's payment for Covered Services or Prescription Drugs subject to the Deductible begins.

DENTAL EMERGENCY SERVICES means only those pediatric dental Services immediately required for alleviation of severe pain, swelling or bleeding, or immediately required to avoid placing the Covered Person's health in serious jeopardy.

DENTAL SPECIALIST SERVICES means Services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics (if Medically Necessary), or pediatric dentistry. Dental Specialist Services must be authorized.

DENTIST means a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which Services are performed.

DETOXIFICATION means a process whereby an alcohol or Drug intoxicated, or alcohol or Drug dependent, individual is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or Drug, alcohol or Drug dependent factors, or alcohol in combination with Drugs as determined by a licensed Physician or Psychologist, while keeping the physiological risk to the individual at a minimum.

DIABETES EDUCATOR means a person who is properly certified pursuant to Florida law, or similar applicable laws of another state, to supervise diabetes outpatient self-management training and educational Services.

DIALYSIS CENTER means an outpatient Facility certified by CMS and AHCA (or a similar regulatory agency of another state) to provide hemodialysis and peritoneal dialysis Services and support.

DIETITIAN means a person who is properly licensed pursuant to Florida law, or similar applicable laws of another state, to provide nutrition counseling for diabetes outpatient self-management Services.

DOMESTIC PARTNER means an adult of the same or opposite sex with whom the Insured is in a Domestic Partnership.

DOMESTIC PARTNERSHIP means the relationship between the Insured and another adult of the same or opposite sex that satisfies all of the following criteria:

- Are in a mutually exclusive relationship similar to marriage;
- Take responsibility for one another's welfare;
- Have not entered into the partnership for the primary purpose of obtaining health insurance;
- Are eighteen (18) years of age or older and are capable to enter into contracts;
- Reside in the same residence and intend to continue to do so;
- Are not blood relatives to the extent that would forbid them from being married in the State of Florida;

- Are both not married, legally separated, or are in divorce proceedings; and
- Are both not currently registered in or have a Domestic Partnership with someone else.

DRUG(S) means any medicinal substance, remedy, vaccine, biological product, Drug, pharmaceutical, or chemical compound that has at least one (1) active ingredient that is FDA-approved and has a valid NDC.

DURABLE MEDICAL EQUIPMENT ("DME") means equipment furnished by a supplier or a Home Health Agency that: 1) can withstand repeated use; 2) is not available OTC; 3) is primarily and customarily used to serve a medical purpose; 4) is not for comfort or convenience; 5) generally is not useful to an individual in the absence of a Condition; and 6) is appropriate for use in the home.

DURABLE MEDICAL EQUIPMENT ("DME") PROVIDER means a person or entity that is properly licensed, if applicable, under Florida law (or similar applicable laws of another state) to provide DME, such as home medical equipment, oxygen therapy Services, or dialysis supplies in the patient's home under a Physician's Prescription.

EFFECTIVE DATE means the date upon which a Covered Person becomes eligible for the Services provided under this Certificate. Coverage first becomes effective, midnight, Eastern Time, on the date so specified on the Individual Plan Information Page.

ELIGIBLE DEPENDENT means an individual who meets and continues to meet all of the eligibility requirements described in the **Eligibility** section in the Certificate.

EMERGENCY MEDICAL CONDITION means:

- A medical Condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
  - Serious jeopardy to the health of a patient, including a pregnant woman or a fetus;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.
- With respect to a pregnant woman:
  - That there is inadequate time to effect safe transfer to another Hospital prior to delivery;
  - That a transfer may pose a threat to the health and safety of the patient or fetus; or
  - That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

EMERGENCY SERVICES AND CARE means a medical screening, examination, and evaluation by a Physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Physician, to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a Covered Service by a Physician necessary to relieve or eliminate the Emergency Medical Condition, within the service capability of a Hospital.

ENROLLMENT DATE means the date of enrollment of an individual under this Certificate.

ENTERAL/PARENTERAL NUTRITION THERAPY – Enteral Therapy means feeding via a tube into the gastro-intestinal tract and does not include nutritional supplements taken orally in any form. Parenteral Nutrition Therapy is the provision of nutrition support intravenously, subcutaneously, intramuscularly, or through some other form of injection.

EXPEDITED APPEAL means an Appeal that is expedited when applying the standard Appeal resolution time frame, and absence thereof would seriously jeopardize the Covered Person's health or ability to regain maximum functionality.

EXPERIMENTAL and INVESTIGATIONAL TREATMENT means any evaluation, treatment, therapy, or device which involves the application, administration, or use of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, Drugs, pharmaceuticals, or chemical compounds, if, as determined solely by the Health Plan:

- Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the FDA or the Florida Department of Health, and approval for marketing has not, in fact, been given at the time such Service is furnished to the Covered Person;
- Such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;
- Such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;
- Evidence considered reliable by the Health Plan showing that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or 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;
- Evidence considered reliable by the Health Plan and which shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
- Evidence considered reliable by the Health Plan and which shows that the evaluation, treatment, therapy, or device has not been proven safe and effective for the treatment of the Condition in question, as evidenced in the most recently published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;
- There is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; and
- Such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

Reliable evidence as defined by the Health Plan may include:

- Records maintained by Physicians or Hospitals rendering care or treatment to You or other patients with the same or similar Condition;
- Authoritative reports, articles, or written assessments, as determined by the Health Plan, medical and scientific literature published in the United States, Canada, or Great Britain;
- Published reports, articles, or other literature of the United States Department of Health and Human Services ("HHS") or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;
- The written protocol or protocols relied upon by the treating Physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device;

- The written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
- The records (including any reports) of any institutional review board of any institution that has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

Note**:** Health Care Services which are determined by Us to be experimental or investigational are excluded (see the **Exclusions and Limitations** section). In determining whether a Health Care Service is experimental or investigational, We may also rely on the predominant opinion among experts, as expressed in the published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

FACILITY means an institution that provides Health Care Services and could include a Hospital, Inpatient Rehabilitation Facility, SNF, or outpatient center.

FDA means the United States Food and Drug Administration.

FORMULARY means the document then in effect issued by Us that may designate the following categories of Prescription Drugs: Preferred Generic Prescription Drugs, Non-Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Brand Name Prescription Drugs, and Specialty Drugs. The Formulary is subject to change at any time. Please refer to Our website at hf.org/healthplans, for the most current Formulary, or You may call Our Customer Service Department at 1.855.443.4735.

FOSTER CHILD means a person who is placed in Your residence and care under the Foster Care Program by the Florida Department of Health and Rehabilitation Services in compliance with Florida Statutes or by a similar regulatory agency of another state in compliance with that state's applicable laws.

FRAUDULENT INSURANCE ACT means a person knowingly and with intent to defraud presenting, causing to be presented, or preparing with knowledge or belief that it will be presented, to or by an insurer, self-insurer, self-insurance policy, or a Claim for payment or other benefit pursuant to any insurance policy that the person knows to contain materially false information concerning any fact material thereto or if the person conceals, for the purpose of misleading another, information concerning any fact material hereto.

GAMETE INTRAFALLOPIAN TRANSFER ("GIFT") means the direct transfer of a mixture of sperm and eggs into the fallopian tube by a qualified Health Care Provider. Fertilization takes place inside the tube.

GENERIC PRESCRIPTION DRUG means a Prescription Drug containing the same active ingredients as a Brand Name Prescription Drug that either: 1) has been approved by the FDA for sale or distribution as the bioequivalent of a Brand Name Prescription Drug through an abbreviated new Drug application under 21 U.S.C. 355 (j); or 2) is a Prescription Drug that is not a Brand Name Prescription Drug, is legally marketed in the United States and is marketed and sold as a generic competitor to its Brand Name Prescription Drug equivalent. All Generic Prescription Drugs are identified by an "established name" under 21 U.S.C. 352 (e), by a generic name assigned by the United States Adopted Names Council, or by an official or non-proprietary name, and may not necessarily have the same inactive ingredients or appearance as the Brand Name Prescription Drug.

GENETIC COUNSELING means meeting with trained health care professionals before testing begins, when the Covered Person receives the test results and for appropriate post-testing follow-

up. Genetic Counseling provides interpretation of Genetic Tests and helps the Covered Person understand genetic disease and how it might affect them.

GENETIC TESTING means any analysis of an individual's deoxyribonucleic acid ("DNA"), ribonucleic acid ("RNA"), chromosomes, proteins, and certain metabolites in order to detect alterations related to a heritable disorder. Testing is performed by directly examining the DNA or RNA that makes up a gene (direct testing), looking at markers co-inherited with a disease-causing gene (linkage testing), assaying certain metabolites (biochemical testing), or examining the chromosomes (cytogenetic testing).

GESTATIONAL SURROGATE means an individual, regardless of age, who contracts, orally or in writing, to become pregnant by means of assisted reproductive technology without the use of an egg from her body.

GRACE PERIOD means the period immediately following the Premium due date during which Premiums may be paid without penalty and Coverage under this Individual Policy continues in effect. However, if Premium is not paid during the Grace Period, Coverage will terminate according to the time frames addressed in the **Grace Period** section. Qualified individuals receiving an APTC through the Marketplace have a three (3) month Grace Period. All other Insureds have a thirty-one (31) calendar day Grace Period.

GRIEVANCE means a formal Complaint regarding Service issues or the quality of care.

GRIEVANCE PROCEDURE means an organized process by which a Covered Person may express dissatisfaction with care or Services received under this Individual Policy.

HABILITATIVE/HABILITATION SERVICES means Health Care Services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapies for a child who is not walking or talking at the expected age. These Services may include PT and OT, speech-language pathology, and other Services for people with disabilities in a variety of Inpatient and/or outpatient settings.

HEALTH BENEFIT PLAN means a health insurance plan of Covered Services described in this Certificate.

HEALTH CARE PROVIDER or PROVIDER(S) means the Physicians, Physician's Assistants, nurses, nurse clinicians, APRNs, pharmacists, marriage and family therapists, clinical social workers, mental health counselors, speech-language pathologists, audiologists, Occupational Therapists, respiratory therapists, Physical Therapists, Ambulance Services, Hospitals, SNFs, or other Health Care Providers properly licensed in the state where they are delivering Health Care Services.

HEALTH CARE SERVICE or SERVICE(S) means treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, Drugs, pharmaceuticals, chemical compounds, and other Services actually rendered or supplied, by or at the direction of a licensed Provider, to Covered Persons under this Certificate.

HEALTH PLAN means Health First Commercial Plans, Inc. d/b/a Health First Health Plans.

HEALTH SAVINGS ACCOUNT ("HSA") means a type of savings account that allows You to set aside money on a pre-tax basis to pay for qualified medical expenses if You have a HDHP. Combining an HDHP with an HSA allows You to pay for certain medical expenses, like Your Deductible and Copayments, with untaxed dollars.

HIGH DEDUCTIBLE HEALTH PLAN ("HDHP") means a plan with a higher Deductible than a traditional insurance plan, as defined by the IRS.

HOME HEALTH AGENCY means a properly licensed agency or organization that provides health Services in the home pursuant to Chapter 400 of the Florida Statutes, or similar applicable laws of another state.

HOME HEALTH CARE or HOME HEALTH CARE SERVICE(S) means Physician-directed professional, technical, and related medical and personal care Services provided on an intermittent or part-time basis directly by (or indirectly through) a Home Health Agency in Your home or residence. For purposes of this definition, a Hospital, SNF, nursing home, or other Facility will not be considered an individual home or residence.

HOME HEALTH CARE VISIT means a period of up to four (4) consecutive hours of Home Health Care Services in a twenty-four (24) hour period. The time spent by a person providing Services under the Home Health Care plan, evaluating the need for, or developing such plan, will be a Home Health Care Visit.

HOSPICE CARE means a public agency or private organization, which is duly licensed by the State of Florida under applicable law, or similar applicable laws of another state, to provide Hospice Services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive care and counseling to terminally ill persons and their families. These Services are provided when the individual is estimated (by a Physician) to have twelve (12) months of life expectancy or less and no longer elects to pursue medical treatment for the terminal illness.

HOSPITAL means a Facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or other state's applicable laws, that offers Services which are more intensive than those required for room, board, personal Services, and general nursing care; offers facilities and beds for use beyond twenty-four (24) hours; and regularly makes available at least clinical laboratory Services, diagnostic x-ray Services, and treatment Facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent.

The term Hospital does not include an Ambulatory Surgical Center; a SNF; stand-alone Birthing Centers; Facilities for diagnosis, care, and treatment of Mental and Nervous Disorders or alcoholism and Drug dependency; convalescent, rest, or nursing homes; or Facilities which primarily provide custodial, education, or Rehabilitative care.

Note: If Services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these Services will not be denied solely because such Hospital lacks major surgical Facilities and is primarily of a Rehabilitative nature. Recognition of these Facilities does not expand the scope of Covered Services under this Certificate. It only expands the setting where Covered Services may be performed for Coverage purposes.

HOSPITAL SERVICE(S) (as expressly limited or excluded by this Certificate) means those Medically Necessary Services for registered bed patients that are: 1) generally and customarily provided by acute general Hospitals in the Service Area; and 2) prescribed or directed by Your PCP and authorized by the Health Plan.

INJURY means an Accidental bodily Injury that:

- Is caused by a sudden, unintentional, and unexpected event or force;
- Is sustained while the Covered Person's Coverage is in force; and
- Results in loss directly and independently of all other causes.

INFERTILE or INFERTILITY means the Condition of a presumably healthy Covered Person who is unable to conceive or produce conception after one (1) year or more of timed, unprotected

coitus, or twelve (12) cycles of AI (for a Covered Person less than thirty-five (35) years of age), or six (6) months or more of timed, unprotected coitus, or six (6) cycles of AI (for a Covered Person thirty-five (35) years of age or older). Infertile or Infertility does not include Conditions for a male Covered Person when the cause is a vasectomy or orchiectomy or for a female Covered Person when the cause is a tubal ligation or hysterectomy with or without surgical reversal.

IN-NETWORK means, when used in reference to Covered Services, the level of benefits payable to an In-Network Provider as designated on Your Schedule of Benefits under the heading "In-Network". Otherwise, In-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is an In-Network Provider under the terms of this Certificate.

IN-NETWORK PROVIDER means any Health Care Provider who, at the time Covered Services were rendered to You, was under contract with the Health Plan to participate in Our Network and included in the panel of Providers designated by the Health Plan as "In-Network" for Your specific plan. Please refer to Your Provider/Pharmacy Directory. For payment purposes under this Individual Policy only, the term In-Network Provider also refers, when applicable, to any Health Care Provider located outside of Our Service Area, who or which, at the time Health Care Services were rendered to You, participated as a Health Plan Provider.

INPATIENT means those Medically Necessary Services that are provided in a Facility that has licensed beds and is referred to as an acute care Facility. The person who is treated as an Inpatient remains in the Facility both days and nights for the period of service.

INPATIENT REHABILITATION FACILITY means a freestanding Inpatient Rehabilitation Facility or Rehabilitation unit of a licensed Hospital certified under Titles XVIII and XIX of the Social Security Act that is under contract with the Health Plan.

INSURED means a person who meets and continues to meet all applicable eligibility requirements, pays the required Premiums, and who is enrolled and Covered under this Certificate, other than as a Covered Dependent.

IN VITRO FERTILIZATION ("IVF") means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to the woman's uterus.

LICENSED PRACTICAL NURSE means a person properly licensed to practice practical nursing pursuant to Chapter 464 of the Florida Statutes, or similar applicable laws of another state.

MAIL ORDER PHARMACY means a Pharmacy that has signed a Mail Services Prescription Drug agreement with Us.

MARKETPLACE is a name used for the Health Insurance Marketplace. This is a shopping and enrollment service for medical insurance created by the ACA in 2010.

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

MATERIAL MISREPRESENTATION means the omission, concealment of facts, or incorrect statements made on any application or enrollment forms by an Applicant or Covered Person, which would have affected Our decision to issue this Certificate, issuance of different benefits, or issuance of this Certificate only at a higher rate, had they been known.

MEDICAL GROUP means any individual practice association or group of licensed doctors of medicine or osteopathy.

MEDICAL LITERATURE means scientific studies published in a United States peer-reviewed national professional journal.

MEDICALLY NECESSARY or MEDICAL NECESSITY means a medical Service or supply that is required for the identification, treatment, or management of a Condition. The medical Service or supply is considered Medically Necessary if, in Our determination, it is:

- Consistent with the symptoms, diagnosis, and treatment of the Covered Person's Condition;
- Widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence;
- Universally accepted in clinical use such that omission of the Service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment;
- Not experimental or investigational;
- Not for cosmetic purposes;
- Not primarily for the convenience of the Covered Person, the Covered Person's family, the Physician, or other Provider; and
- The most appropriate level of service, care, or supply which can safely be provided to the Covered Person. If the safety and the efficacy of all alternatives are equal, the Health Plan will provide Coverage for the least costly alternative. When applied to Inpatient care, Medically Necessary further means that the Services cannot be safely provided to the Covered Person in an alternative setting.

Note: It is important to remember that any review of Medical Necessity by Us is solely for the purpose of determining Coverage or benefits under this Certificate and not for the purpose of recommending or providing medical care. In this respect, We may review specific medical facts or information pertaining to You. Any such review, however, is strictly for the purpose of determining, among other things, whether a Service provided or proposed meets the definition of Medical Necessity in this Certificate as determined by Us. In applying the definition of Medical Necessity in this Certificate, We may apply Our Coverage and payment guidelines then in effect. You are free to obtain a Service even if We deny Coverage because the Service is not Medically Necessary, however, You will be solely responsible for paying for the Service.

MEDICALLY NECESSARY LEAVE OF ABSENCE means, with respect to a dependent child in connection with an individual health insurance coverage, a leave of absence of such child from a postsecondary educational institution (including an institution of higher education as defined in the regulations), or any other change in enrollment of such child at such an institution, that:

- Commences while such child is suffering from a serious illness or Injury;
- Is Medically Necessary; and
- Causes such child to lose student status for purposes of coverage under the terms of the plan or coverage.

MEDICALLY NECESSARY ORTHODONTIC SERVICES means orthodontic Services to help correct severe handicapping malocclusions or severely misaligned teeth, causing functional problems that compromise oral and/or general health. Severe handicapping malocclusion is not a cosmetic Condition. Medically Necessary Orthodontic Services require Prior Authorization.

MEDICARE means the health insurance programs under Title XVIII of the United States Social Security Act of 1965, as then constituted or as later amended.

MENTAL HEALTH PROFESSIONAL means a person properly licensed to provide Mental Health Services, pursuant to Chapter 491 of the Florida Statutes, or similar applicable laws of another state. This professional may be a clinical social worker, mental health counselor, or marriage and family therapist. A Mental Health Professional does not include members of any religious denomination or sect who provides counseling Services.

MENTAL and NERVOUS DISORDER means any disorder set forth in the diagnostic categories of the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder. Examples include Attention Deficit Hyperactivity, Bipolar affective disorder, Autism, intellectual disability, and Tourette's syndrome.

MIDWIFE means a person properly licensed to practice midwifery pursuant to Chapter 467 of the Florida Statutes, or similar applicable laws of another state.

NATIONAL DRUG CODE ("NDC") means the universal code that identifies the Drug dispensed. There are three (3) parts of the NDC, which are as follows: the labeler code (first five (5) digits), product code (middle four (4) digits), and the package code (last two (2) digits).

NETWORK or NETWORK PROVIDER means the same definition as Participating Provider.

NEWBORN means a child who is within twenty-eight (28) days of birth.

NON-PARTICIPATING PHARMACY means a Pharmacy that has not agreed to participate in the Health Plan's Pharmacy Network.

NON-PARTICIPATING PROVIDER means a Non-Participating Health Care Provider (a Hospital, Physician, Physician extender, Pharmacy, or other Provider) that has not agreed to participate in Our Network, and who is not published in the Provider/Pharmacy Directory as Participating.

NON-PREFERRED PRESCRIPTION DRUG means a Prescription Drug that is not included on the Preferred Formulary tier then in effect.

NURSING SERVICES means Services that are provided by a Registered Nurse, Licensed Practical Nurse, or a License Vocational Nurse who is:

- Acting within the scope of that person's license;
- Authorized by a Physician; and
- Not a member of the Covered Person's immediate family.

OCCUPATIONAL THERAPIST means a person properly licensed to practice OT pursuant to Chapter 468 of the Florida Statutes, or similar applicable laws of another state.

OCCUPATIONAL THERAPY ("OT") means a treatment that follows an illness or Injury and is designed to help a patient learn to use a newly restored or previously impaired function.

OPEN ACCESS means a Covered Person may access Covered Services from any participating Specialist without a referral from the Covered Person's PCP. Note: Certain Specialists will not accept direct appointments from a Covered Person and will require a referral in order for the Covered Person to be seen.

OPEN ENROLLMENT PERIOD ("OEP") or OPEN ENROLLMENT means the period of time, as determined by the Marketplace or the Health Plan, during which individuals who are eligible to enroll can enroll in a plan offered by the Health Plan or in a plan offered through the Marketplace. Each year, individuals have a chance to make changes to their Coverage on the Marketplace during Open Enrollment. Individuals may also qualify for SEPs outside of Open Enrollment if they experience certain events.

ORTHOTIC DEVICE means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.

OUT-OF-AREA URGENT CARE means Urgent Care rendered while the Covered Person is temporarily outside of this Individual Policy's Service Area.

OUT-OF-NETWORK means, when used in reference to Covered Services, the level of benefits payable to an Out-of-Network Provider as designated on Your Schedule of Benefits under the heading "Out-of-Network".

OUT-OF-NETWORK DENTAL PROVIDER means a dental Provider who is not contractually bound to abide by the third party dental Provider's administrative guidelines.

OUT-OF-NETWORK PROVIDER(S) means a Provider who, at the time Health Care Services were rendered, did not have an agreement with Us to participate in the Health Plans Network.

OUT-OF-POCKET MAXIMUM EXPENSE LIMIT means the maximum amount of Covered expenses each Covered Person pays every Calendar Year before benefits are payable at one hundred percent (100%) for the remainder of the Calendar Year. Certain expenditures may be excluded from the calculation, such as expenses related to charges for Services not Covered by this Individual Policy and expenses that relate to Services that exceed specific treatment limits.

OUTPATIENT REHABILITATION FACILITY means an entity which renders, through Providers properly licensed pursuant to Florida law, or similar laws of another state, any of the following: outpatient PT, outpatient ST, outpatient OT, and outpatient cardiac Rehabilitation Therapy for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet Our criteria for eligibility as an Outpatient Rehabilitation Facility. The term Outpatient Rehabilitation Facility, as used herein, shall not include any Hospital, including a general acute care Hospital, or any separately organized unit of a Hospital which provides comprehensive medical Rehabilitation Inpatient Services, or Rehabilitation outpatient Services, including a Class III "specialty Rehabilitation Hospital" described in the Florida Administrative Code or the similar laws of another state.

OVER-THE-COUNTER ("OTC") means supplies that can be obtained without a Prescription.

OUTPATIENT SURGERY means any procedure performed in an Ambulatory Surgery Center or Hospital Facilities, including diagnostic tests or any other minor procedures.

PAIN MANAGEMENT means Services for pain assessment, medication, PT, biofeedback, and/or counseling. Pain Rehabilitation programs are programs featuring multidisciplinary Services directed toward helping those with chronic pain to reduce or limit their pain.

PALLIATIVE CARE means specialized medical care for people living with a serious illness. Palliative Care is focused on providing relief from the symptoms and stress of the illness to improve quality of life for both the patient and family.

PARTIAL DISABILITY means having a Condition from an illness or Injury that prevents the individual from performing some part or all of the "major," "important," or "essential" duties of one's employment or occupation and the individual is under the regular care of a PCP. Determination of Partial Disability shall be made by the PCP on the basis of a medical examination of the Covered Person and upon concurrence by the Health Plan's Medical Director.

PARTIAL HOSPITALIZATION means treatment in which an individual receives at least seven (7) hours of institutional care during a portion of a twenty-four (24) hour period and returns home or leaves the treatment Facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

PARTICIPATING DENTAL PROVIDER means, or refers to, the preferred Dental Provider Network designated by the Health Plan that is available to the Health Plan's Covered Persons under this Certificate.

PARTICIPATING PHARMACY means, for Pharmacies located in the Service Area, a Pharmacy that has signed a Participating Pharmacy Provider agreement with Us to participate in the Health Plan's Pharmacy Network.

PARTICIPATING PROVIDER(S) means, or refers to, the preferred Provider Network established and so designated by the Health Plan that is available to the Health Plan's Covered Persons under this Certificate. This includes a participating Hospital, a participating Physician, or other participating Health Care Provider who has made an agreement with the Health Plan to provide Services to Covered Persons and is published as such in the Health Plan's Provider/Pharmacy Directory.

PARTICIPATING VISION PROVIDER means, or refers to, the preferred vision Provider Network designated by the Health Plan that is available to the Health Plan's Covered Persons under this Certificate.

PEDIATRIC DENTAL BENEFIT(S) means the pediatric oral Services, classified as essential health benefits, which are required to be included for eligible pediatric Covered Persons under the ACA.

PEDIATRIC VISION BENEFIT(S) means the pediatric vision Services, classified as essential health benefits, which are required to be included for eligible pediatric Covered Persons under the ACA.

PHARMACY means an establishment licensed as a Pharmacy pursuant to Chapter 465 of the Florida Statutes, or similar applicable laws of another state, where Pharmacists dispense Prescription Drugs.

PHYSICAL THERAPIST means a person properly licensed to practice PT pursuant to Chapter 486 of the Florida Statutes, or similar applicable laws of another state.

PHYSICAL THERAPY ("PT") means the treatment of disease or Injury by physical or mechanical means as defined in Chapter 486 of the Florida Statutes, or similar applicable laws of another state. Such therapy may include traction, active or passive exercises, or heat therapy.

PHYSICIAN(S) means an individual who is: (a) licensed to practice medicine and/or surgery; or (b) any other licensed practitioner of the healing arts who is practicing within the scope of his or her license and whose Services are required to be Covered under this Certificate by the laws of the jurisdiction where treatment is given or is a partnership or professional association or corporation of such individuals in subsection (a) or (b), is a person properly licensed to practice medicine pursuant to Florida law, or another state's applicable laws, including:

- Doctor of Medicine ("MD") or Doctor of Osteopathy ("DO");
- Doctor of Dental Surgery or Dental Medicine ("DDS." or "DMD");
- Doctor of Chiropractic ("DC");
- Doctor of Optometry ("OD") or Ophthalmology; and
- Doctor of Podiatry ("DPM").

PHYSICIAN ASSISTANT means a person properly licensed pursuant to Chapter 458 of the Florida Statutes, or similar applicable laws of another state.

POST-SERVICE CLAIM means any request or application for Coverage or benefits for a Service that has been provided to You. A Post-Service Claim is any Claim for a benefit under this Individual Policy that is not a Pre-Service Claim, an Urgent Care Claim, or a Concurrent Care Claim.

PREFERRED PRESCRIPTION DRUG means a Prescription Drug on the Preferred Formulary tier then in effect. The Preferred tier is contained within the Formulary.

PREMIUM means the amount established by the Health Plan to be paid to the Health Plan by the Insured or on behalf of the Insured, if permissible, in consideration of the benefits provided under this Individual Policy.

PRESCRIPTION means an order for Drugs, Services, or supplies by a Physician or other Health Care Provider authorized by law to prescribe such Drugs, Services, or supplies.

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

PRE-SERVICE CLAIM means a Claim the Health Plan specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the Claim involves Urgent Care. Benefits under this Certificate that require approval in advance are specifically noted in the Health Plan's Authorization List as being subject to Prior Authorization.

PREVENTIVE HEALTH SERVICE(S) or PREVENTIVE means routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

PRIMARY CARE PHYSICIAN ("PCP") is a Family Practitioner, Internist, Pediatrician, or Physician Extender (Physician Assistant or APRN) licensed to provide, prescribe, and authorize care and treatment for Covered Persons. In addition, a female Covered Person may select as her PCP an OB/GYN who has agreed to serve as a PCP and is in the Health Plan's Provider Network. A current listing of contracted PCPs is published in the Plan's Provider/Pharmacy Directory as "Participating".

PRIOR AUTHORIZATION or AUTHORIZATION means prior approval by the Health Plan to determine Medical Necessity. Authorization is required for certain Services to be Covered. The Physician requesting the Service is required to submit all necessary clinical information along with the request to the Health Plan for review and approval.

PROPHYLACTIC MASTECTOMY means the surgical removal of one (1) or both breasts to reduce the risk of breast cancer in high-risk individuals. It is also known as Preventive or risk-reducing Mastectomy.

PROSTHETIC DEVICE means a device that replaces all or part of a body part or an internal body organ or replaces all or part of the functions of a permanently inoperative or malfunctioning body part or organ.

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

PROVIDER(S) means any Facility, Pharmacy, Physician, person, or entity recognized for payment by the Health Plan under this Individual Policy.

PROVIDER DIRECTORY means a listing of all contracted Participating Providers for the plan of which You are a Covered Person. Copies of this Directory are available on Our website, hf.org/healthplans, and will be furnished to You upon request.

PSYCHIATRIC FACILITY means a Facility properly licensed under Florida law, or similar applicable laws of another state, to provide for the Medically Necessary care and treatment of

Mental and Nervous Disorders. For the purposes of this Individual Policy, a Psychiatric Facility is not a Hospital or a SUD Facility.

PSYCHOLOGIST means a person properly licensed to practice psychology pursuant to Chapter 490 of the Florida Statutes, or similar applicable laws of another state.

QUALIFIED HEALTH PLAN ("QHP") means an insurance plan that has been certified by the Marketplace, provides essential health benefits, follows established limits on Cost-Sharing, and meets all other requirements under the ACA. All Qualified Health Plans meet the ACA requirement for having health Coverage, known as "Minimum Essential Coverage".

RECONSTRUCTIVE SURGERY means surgery that is incidental to an Injury, Sickness or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. For the purpose of Coverage under this Individual Policy, the initial Breast Reconstruction following Mastectomy, to reestablish symmetry between the two (2) breasts, is considered to be Reconstructive Surgery. A congenital anomaly is a defective development or formation of a part of the body, in which the defect is determined by a Physician to have been present at the time of birth.

REGISTERED NURSE means a person properly licensed to practice professional nursing pursuant to Chapter 464 of the Florida Statutes, or similar applicable laws of another state.

REGISTERED NURSE FIRST ASSISTANT means a person properly licensed to perform surgical first assisting Services pursuant to Chapter 464 of the Florida Statutes, or similar applicable laws of another state.

REHABILITATION SERVICES means Services for the purpose of restoring function lost due to illness, Injury, or surgical procedures, including cardiac Rehabilitation, pulmonary Rehabilitation, OT, ST, and PT.

REHABILITATION THERAPY means the short-term physical, speech, hearing, or respiratory therapy that a participating Physician and the Health Plan's Medical Director have determined will result in a significant improvement in the Condition.

RESIDENTIAL TREATMENT FACILITY means a community-based residence for individuals exhibiting symptoms of mental illness who are in need of a structured living environment.

RESPITE CARE means care furnished during a period of time when the Covered Person's family or usual caretaker cannot, or will not, attend to the Covered Person's needs.

SCHEDULE OF BENEFITS means the document that summarizes Your Coverage under the Health Benefit Plan and states the Cost-Sharing amounts Covered Persons must pay for Covered Services.

SERVICE AREA means the geographic area in which the Health Plan is authorized to provide health Services as approved by AHCA. The Health Plan's Service Area is all of Brevard, Flagler, Indian River, Seminole, and Volusia Counties.

SICKNESS means bodily disease for which expenses are incurred while Coverage under this Individual Policy is in force.

SKILLED NURSING CARE means skilled nursing services, above the level of Custodial Care, which are Medically Necessary, ordered by a Provider, and provided by a licensed SNF.

SKILLED NURSING FACILITY ("SNF") means an institution that meets all of the following requirements:

- It must provide treatment to restore the health of sick or injured persons;

- The treatment must be given by or supervised by a Physician. Nursing Services must be given or supervised by a Registered Nurse;
- It must not primarily be a place of rest, a nursing home, or a place of care for senility, Drug addiction, alcoholism, intellectual disability, psychiatric disorders, chronic brain syndromes, or a place for the aged;
- Is licensed as a SNF by the State of Florida or similar applicable laws of another state; and
- Is accredited as a SNF by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a SNF by the Secretary of HHS of the United States under Medicare, unless such accreditation or recognition requirement has been waived by the Health Plan.

SKIN SUBSTITUTES means a heterogeneous group of biologic, synthetic, or biosynthetic materials that can provide temporary or permanent coverage of open skin wounds. The aim of Skin Substitutes is to replicate the properties of the normal skin.

SOUND NATURAL TEETH means teeth that are whole or properly restored (restoration with amalgams, resin, or composite only); are without impairment, periodontal, or other Conditions, and are not in need of Services provided for any reason other than an Accidental Dental Injury. Teeth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated with endodontics are not Sound Natural Teeth.

SPECIAL ENROLLMENT PERIOD ("SEP") means a time outside of the OEP during which You and Your family have a right to enroll into health Coverage or make changes to Your health insurance plan following certain qualifying life events that involve a change in family status (i.e., marriage, divorce, or birth of a child) or the loss of other health coverage. The SEP is available up to sixty (60) days following the qualifying life event.

SPECIALIST(S) means a Physician or his or her Physician Extender (i.e., Physician Assistant or APRN) who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

SPECIALTY DRUG means an FDA-approved Prescription Drug that has been designated by Us as a Specialty Drug due to requirements such as special handling, storage, training, distribution, and management of the therapy.

SPEECH THERAPIST means a person properly licensed to practice ST pursuant to Chapter 468 of the Florida Statutes, or similar applicable laws of another state.

SPEECH THERAPY ("ST") means the treatment of speech and language disorders by a Speech Therapist, including language assessment and language restorative therapy Services.

SPOUSE means any individuals who are lawfully married under any state law, including individuals married to a person of the same sex.

SUBSTANCE USE DISORDER ("SUD") means a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications. Symptoms can range from moderate to severe, with addiction being the most severe form of SUDs.

SUBSTANCE USE DISORDER ("SUD") FACILITY means a Facility properly licensed under Florida law, or similar applicable laws of another state, to provide necessary care and treatment for Substance Dependency. For the purposes of this Individual Policy, a SUD Facility is not a Hospital or a Psychiatric Facility, as defined herein.

SUBSTANCE DEPENDENCY means a Condition where a person's alcohol or Drug use injures his or her health, interferes with his or her social or economic functioning, or causes the individual to lose self-control.

SURPRISE BILL(ING) means an unexpected Balance Bill. For example, this can occur when You have an Emergency or when You schedule a visit at an In-Network Facility, but are unexpectedly treated by an Out-of-Network Provider.

TELEHEALTH means the use of synchronous or asynchronous telecommunications technology by a Telehealth Provider to provide Health Care Services including assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

TRANSPLANT means a replacement of solid organs, stem cells, bone marrow, or tissue.

TOTALLY DISABLED means for an adult Covered Person, having a Condition from an illness or Injury that prevents the individual from engaging in any employment or occupation for which the individual is or may become qualified by education, training, or experience and the individual is under the regular care of a PCP. For Covered Persons who are children, Totally Disabled means a persistent physical impairment resulting from an Injury or illness. Determination of total disability shall be made by the PCP on the basis of a medical examination of the Covered Person and upon concurrence by the Health Plan's Medical Director. The period of total disability must be expected to extend for at least six (6) months.

URGENT CARE means medical screening, examination, and evaluation received in an Urgent Care Center, and the Covered Services for those Conditions which, although not life-threatening, could result in serious Injury or disability if left untreated.

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

URGENT CARE CLAIM means a special type of Pre-Service Claim. A Claim involving Urgent Care is any Pre-Service Claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to Pre-Service Claims could seriously jeopardize the Covered Person's life or health or ability to regain maximum function or would, in the opinion of a Physician with knowledge of the Covered Person's medical Condition, subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

UTILIZATION MANAGEMENT/QUALITY MANAGEMENT (UM/QM) PROTOCOLS means those procedures adopted by the Health Plan to ensure that the Covered Services provided to Covered Persons are Medically Necessary and that Preventive, acute, and tertiary care are provided to Covered Persons consistent with the provision of quality care in the most cost-effective manner available.

WE, US, OUR means Health First Commercial Plans, Inc. d/b/a Health First Health Plans.

YOU, YOUR(S), YOURSELF means the Covered Persons who are Covered under this Individual Policy.

XII. NOTICES

A. STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, the Health Plan generally may not restrict Coverage for any Hospital length of stay, in connection with childbirth for the mother or Newborn child, to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the Health Plan may pay for a shorter stay if the attending Provider (Physician, Nurse Midwife, or Physician Assistant), after consultation with the mother, discharges the mother or Newborn child earlier than the forty-eight (48) or ninety-six (96) hours described above.

Also, under federal law, the Health Plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or Newborn than any earlier portion of the stay. Complications of pregnancy must be treated the same as any other illness.

In addition, the Health Plan may not, under federal law, require that a Physician or other Health Care Provider provide prior notification before prescribing a length of stay of up to forty-eight (48) hours (or ninety-six (96) hours).

B. FLORIDA AGENCY FOR HEALTHCARE ADMINISTRATION ("AHCA")

In accordance with Florida Statutes, AHCA establishes and maintains a Florida Center for Health Information and Transparency to collect, compile, coordinate, analyze, index, and disseminate health-related data and statistics. The Health Plan has incorporated a link on the Health Plan's website to the AHCA information that is required by law. The Health Plan's website address is: hf.org/healthplans.

XIII. COVERED PERSONS RIGHTS AND RESPONSIBILITIES

We value Our relationship with You and believe that setting clear expectations about Our partnership is a critical part of earning Your trust. The following rights and responsibilities represent the cornerstone of Our successful future, and We encourage You to become familiar with them.

As a Covered Person, You have the right:

- To receive these rights and responsibilities, as well as other information about Your plan and its benefits, Services, and Providers;
- To be treated with respect and recognition of Your dignity and right to privacy. See Our Notice of Privacy Practices for additional information on how We protect Your information;
- To participate with Providers in decisions involving Your health care, considering ethical, cultural, and spiritual beliefs, unless concern for Your health indicates otherwise;
- To have a candid discussion of appropriate or Medically Necessary treatment options for Your Conditions, regardless of cost or benefit Coverage. You have the right to receive this information in terms You understand;
- To receive a prompt response when You ask questions or request information;
- To be informed of who is providing Your medical care and who is responsible for Your care;
- To be informed if Your Health Care Provider plans to use Experimental Treatment for Your care. You have the right to refuse to participate in such Experimental Treatment;

- To receive a reasonable estimate of charges for Your medical care and a copy of an itemized bill, reasonably clear and understandable and have the charges explained to You;
- To receive information about Copayments and fees that You are responsible to pay;
- To know what patient support Services are available to You, including whether an interpreter is available if You do not speak English;
- To be informed about Your diagnosis, testing, treatments, and prognoses. When concern for Your health makes it inadvisable to give such information to You, such information will be made available to an individual designated by You or to a legally authorized individual;
- To be informed about consent to treatment, Your right to refuse treatment to the extent permitted by law, and the consequences of Your refusal. When refusal prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the Covered Person may be terminated by the Provider upon reasonable notice;
- To receive quality, timely health care with respect and compassion regardless of race, ethnicity, national origin, age, sex, gender, religious beliefs, source of payment, health status, medical Condition, including physical and mental illnesses, Claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including Conditions arising out of acts of domestic violence, disability, or geographic location within this Service Area;
- To receive treatment for any Emergency Medical Condition that will get worse from failure to obtain the treatment;
- To determine the course of Your treatment by issuing "advance directives." In accordance with the federal law titled "Patient Self-Determination Act" and Chapter 765 of the Florida Statutes titled "Health Care Advance Directives," You can make future healthcare decisions now with these types of advance directives:
    - The "living will" states which medical treatments You would accept or refuse if You became permanently unconscious or terminally ill and unable to communicate; and
    - The "durable power of attorney for health care" or "designation of a health care surrogate" allow You to appoint someone else to make decisions regarding Your health care when You are temporarily or permanently unable to communicate;
- To have Your medical records kept private, except when You provide Your consent or when permitted by law;
- To choose a primary doctor to coordinate Your care and to change Your doctor at any time;
- To receive information about Our quality improvement programs, including the progress being made;
- To make recommendations regarding Our Covered Person's Rights and Responsibilities policies;
- To receive information and necessary counseling on the availability of known financial resources for Your care;
- To know what rules and regulations apply to Your conduct; and
- To voice concerns or Appeals about Your benefits, Our Service, or the care provided.

Additionally, You have the responsibility:

- To understand Your Covered Services and the rules You must follow to get these Covered Services;

- To inform Us if You have other health insurance coverage in addition to this Individual Policy;
- To supply accurate and complete information, including unexpected changes in Your health Condition, (to the extent possible) that Your plan and Your Providers need in order to provide You care;
- To provide Your doctor, to the best of Your knowledge, accurate and complete information about any current medical complaints, past medical history, and any other information relating to Your health;
- To understand Your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible;
- To follow the plans and instructions for care that You have agreed on with Your Providers;
- To be responsible for Your actions if You refuse treatment or do not follow Your Health Care Provider's instructions;
- To follow the Provider's rules and regulations affecting patient care and conduct, including keeping Your appointments and arriving promptly, and notifying Your Physician if You're unable to keep a scheduled appointment in a timely fashion;
- To pay Your Cost-Share or any other applicable fees according to Your plan documents;
- To notify Us of any changes in Your address, telephone number, or eligibility status; and
- If You are enrolled in an HMO plan, to use the designated Participating PCPs, Specialists, Medical Facilities, and suppliers (except for Emergency or Urgent Care).

XIV. NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The HIPAA Privacy Rule requires Health Care Providers and health plans to develop and distribute a notice that provides a clear, user-friendly explanation of customers' rights with respect to their personal health information and the privacy practices related to that information.

Our Pledge

This notice applies to all customers receiving Services from Health First, Inc., Health First Medical Group, LLC, Health First Privia Medical Group, LLC1 and/or Health Plan2. Health First is committed to improving the wellness and health of Our customers and community. We want You, Our customers, to feel supported and informed about Your care and Coverage. This includes explaining how We use, manage and safeguard Your information and Your rights and choices related to Your information.

If You have any questions about this notice, please contact the Health First Privacy Office at 321.434.7543.

Your Information

In this notice, information refers to any information that identifies You, as a current or former Health First customer, and relates to Your health or Condition, Your Health Care Services, payment or Coverage for those Services. It includes Claims and Coverage information, and health information, like diagnosis and Services You received. It includes demographic information like Your name, address, phone number and date of birth. It includes information that comes from You or results from You doing business with Us, Our affiliates or others, such as enrollment, prior approvals, referrals, Coverage determinations, Claims and payment information.

How We safeguard Your information

We allow access to Your information by Our workforce members but only to the extent they need that information for treatment, payment, healthcare operations and/or to administer Your

health plan and benefits, comply with legal or accreditation requirements, or as otherwise allowed by law. As such, and in order to provide Our customers with necessary, appropriate, and timely continuity of care, Health First entities have several electronic platforms, systems, and applications that share Your information throughout Our Integrated Delivery Network ("IDN") and the community where needed and permitted for treatment, payment and healthcare operations and in accordance with applicable law.

We maintain physical, electronic and administrative safeguards designed to protect Your information and prevent unauthorized access.

How do We typically use and share Your information?
We may share Your information without Your written authorization for the following purposes:

For Treatment:
To share with Health Care Providers (doctors, dentists, pharmacies, Hospitals and other caregivers) for Your treatment or to coordinate preventive health, early detection and disease and case management programs.

Example: Your doctor sends Us information about Your diagnosis and treatment plan so We can help arrange for additional Services.

Please note, that We do not need Your permission to share Your information in a medical emergency, if You are unable to give Us permission due to Your Condition. Also, the organizations covered by this notice do not need Your permission to share Your information with each other, as long as it is for a permitted purpose.

For Payment:
To pay or receive payments for care that You receive.

Example: We may contact Your Providers to coordinate Your benefits and to confirm eligibility and Coverage or We might contact Your health plan to pay for Services You received at Our Facilities.

For Healthcare Operations:
To support daily business activities for healthcare operations.

Example: We use and disclose Your information to tell You about plan benefits, treatment alternatives or health-related products and Services. We use Your information for quality management, improvement activities, care coordination and for underwriting purposes. We also use Your information to contact You regarding Your appointments or for fundraising activities. If You do not want to be contacted by Health First for fundraising efforts, You must notify the Health First Foundation in writing at ATTN: Foundation Gift and Data Specialist, 1350 S. Hickory St., Melbourne, FL 32901 or by phone at 321.434.7353. Unless You tell Us otherwise, We may include some limited information about You in Our directory. This information might include Your name, location and general Condition. We might share this information with Your family members and friends unless You tell Us otherwise.

To administer Your plan:
We may share Your information with Our affiliates (also known as related organizations) that help Us administer and manage Our Health Plan. We may also share Your information with non-affiliated (non-related) third parties permitted by HIPAA. These organizations are generally known as Business Associates. Health First contracts with these Business Associates to provide certain products or Services on Our behalf. Business Associates are required by law to safeguard Your information the same way We do.

Other uses and disclosures:

We may also share Your information with other third parties, including regulatory authorities, government agencies or law enforcement, as allowed or required by law.

The Health Plan in providing fully insured benefits to a group health plan, or helping administer the benefits of a self-insured group health plan, may, if requested, share limited information with the sponsor of Your group health plan, for plan administration purposes, if certain privacy requirements are met.

Example: For a fully insured plan, the Health Plan may share certain statistics with Your employer to explain the Premiums We charge.

We use or share Your information if state or federal law requires it.

Public health and safety issues:
We share Your information with public health authorities or other authorized agencies in certain situations such as:

- Prevent disease
- Help with product recalls
- Report adverse reactions to medications
- Report suspected abuse, neglect, domestic violence or crimes in Our care locations
- Prevent or reduce a serious threat to anyone's health or safety
- Help with health system oversight, such as audits or investigations
- Comply with special government functions such as military, national security, presidential protective services and disclosures to correctional facilities.

Respond to organ and tissue donation requests:
We use and share Your information to help with organ or tissue donation.

Work with a medical examiner or funeral director:
We share Your information with a coroner, medical examiner or funeral director.

Handle workers' compensation:
We use and share Your information for Your workers' compensation Claims.

Respond to lawsuits and legal actions:
We can use and share Your information for legal actions, or in response to a court or administrative order, or other lawful process. We can share Your information with authorized law enforcement officials.

Organized Health Care Arrangement (OHCA)
Health Plan participates in two distinct Organized Health Care Arrangements (OHCA) under the HIPAA. An OHCA is an arrangement that allows covered entities, which are a Health Care Provider, health plan or healthcare clearinghouse, to share Protected Health Information (PHI) about their customers, person receiving Services, or plan members to provide Health Care Services, to perform payment and to perform healthcare operations. Health Plan participates in one OHCA with AdventHealth and its Florida-based affiliates. Health Plan also participates in a separate OHCA with other Health First, Inc. entities. Please contact Our Privacy Office if You would like to know what Networks or accountable care organizations Health Plan participates in.

Uses and disclosures that require Your authorization:
For any other purposes not described in this document, We must obtain Your written authorization to use or share Your information. For example, We would need Your authorization:

- For uses and disclosures of psychotherapy notes.
- To use Your information for marketing purposes for which financial payment is received.

- For any sale involving Your information resulting in financial or non financial payment.

Your Individual Rights:
You have certain rights regarding information that Health First creates, obtains or maintains about You. To exercise these rights, please contact Us at the location below:

Health First
Health Information Management Department
3300 S. Fiske Blvd., Building B
Rockledge, FL 32955

Review or get a copy of Your information
You can ask to see or get a copy of our information stored in paper or electronic records. We will provide a copy or a summary of Your information. If there are records that We cannot share or if We need to limit access, We will inform You as to this fact. We may charge a fee to process Your request.

Ask Us to correct Your information (Amendment)
You can ask Us in writing to correct Your information if You feel that it is incorrect or incomplete. We will correct the information if allowed by law. We may say "no" to Your request, but We will explain the reason in writing. If Your request is denied, You can ask Us to keep a copy of Your disagreement (a written statement You provide to us) with Your records.

Ask Us to limit what We use or share (Restriction)
You can ask Us in writing not to use or share Your information. We will always consider Your request, but We may say "no" if it would affect Our ability to provide care or Service to You or cause a customer safety concern. If We agree to the restrictions, We will abide by them.

Request confidential communications
You can ask Us in writing to contact You in a specific way or at a specific location (for example, home or office phone). We will not ask You the reason of Your request and We will accommodate all reasonable requests.

For Health Plan customers: If You notify Us that a possible communication could endanger You, We must accommodate Your reasonable request for confidential communications.

Get a list of who has received Your information (Accounting of Disclosures)
You can ask Us for a list of the times We have shared Your information with outside organizations or customers, who We shared it with, and why. Your request must be in writing and must include a specific time period.

We will include any disclosure that occurred within the last six years of Your request, where We have shared Your information, except for when it was about Your treatment, payment for Your treatment or health care operations. We will provide You with the date of disclosure, the name of the entity or person who received the information and a brief description of the information disclosed.

Get a copy of this notice
We reserve the right to change this notice. The changes will apply to all information We have about You. If We make any changes, We will post the new notice at all Health First locations and websites. We will provide a current copy to You upon enrollment, annually and when You receive Services at any Health First entity. Health Plan customers, however, will receive this notice upon enrollment and no less frequently than once every three years. Unless You are a Health Plan customer, We are required to ask You to sign an acknowledgment that You have received this notice.

You can ask for a paper copy of this notice at any time even if You agreed to receive this notice electronically. We will provide it as requested.

We may provide this notice to You by email if You have agreed to receive electronic notification. We are required by law to follow the privacy notice that is in effect at this time. This notice is also available on Our website at HF.org.

File a Complaint if You feel Your privacy rights have been violated
You can complain directly to Us if You feel We have violated Your privacy rights by contacting Us using the information available at the end of this notice. You can also file a Complaint with the U.S. Department of Health and Human Services Office for Civil Rights. Find contact information at *www.hhs.gov/ocr/privacy/hipaa/complaints*. We won't retaliate against You for making a Complaint.

Your Choices
In some situations, You have additional choices about how We use and share Your information. If You have a preference in the situations described in this document, let Us know. Tell Us what You want Us to do, and We will follow Your instructions while following the law.

You can tell Us not to:
Share Your information with Your family, close friends or others involved in Your care or payment for Your care.

You can also tell Us not to share Your information with others for health research (we can still use Your information for Our own research as long as We follow the law).

Our Responsibilities:
- We protect Your information because Your privacy is important to Us, and because it is the law.
- We must follow the responsibilities and privacy practices described in this notice.
- We must make this notice available to You when You become a customer and must post it online at HF.org
- We will let You know in accordance with the law if a breach (unauthorized access, use or sharing) occurs that may have put the privacy of Your information at risk.
- We will not use or share Your information except as covered in this notice, unless You tell Us We can in writing. You may revoke Your authorization at any time. Let Us know in writing if You change Your mind.
- When the law requires Us to get Your permission in writing before We use or share Your information, We will do so.
- We will not use Your genetic information to decide whether We will give You Coverage and the price of that Coverage.

Health Information Exchange Opt-Out-Health First Medical Group, LLC and Health First Privia Medical Group, LLC ONLY
Health First Privia Medical Group, LLC participates in a Health Information Exchange ("HIE"). You have the right to opt out of disclosure of Your medical records to or via an electronic health information exchange ("HIE"). However information that is sent to or via an HIE prior to processing Your opt-out may continue to be maintained by and be accessible through the HIE. You must opt out of disclosures to or via an HIE through each of Your individual treating Providers who may participate in any given HIE. To opt out, You will need to fill out the Health First Privia Medical Group, LLC HIE Opt-Out Request Form ("Request Form") and/or contact the HIE directly. To receive a Request Form or for other information regarding the HIE, please contact Your Health First Medical Group, LLC or Health First Privia Medical Group, LLC physician office. If You decide later on that You want to opt back into the HIE, You may do so by

submitting the Health First Privia Medical Group, LLC Reinstatement of Participation Form ("Reinstatement Form"). To receive a Reinstatement Form, please contact Your Health First Medical Group, LLC or Health First Privia Medical Group, LLC physician office.

In addition to contacting Your Physician office, if You have questions regarding the HIE or to receive the Request Form or the Reinstatement Form, You can email privacy@priviahealth.com. Additionally, to opt out of the HIE, please email medicalrecords@priviahealth.com.

For information, questions or Complaints

You may get more information about Our privacy practices and Your privacy rights by calling Health First Chief Privacy Officer at 321.434.7543. You can also find this information online at HF.org. You can also contact the Health First HIPAA and Compliance Hotline at 1.888.400.4512.

Effective: April 1, 2003
Revised: July 2016, October 2019, January 2020

[1]Health First Privia Medical Group, LLC is a Limited Liability Company attached to the Health First Shared Services, Inc. IDN but is owned by community Physicians.

[2]For the purpose of this notice, Health First Health Plans, Inc., Health First Administrative Plans, Inc., Health First Commercial Plans, Inc., Health First Insurance, Inc., and AdventHealth Advantage Plans are herein referred to as "Health Plan."