HEALTH FIRST COMMERCIAL PLANS, INC.
6450 U.S. Highway 1
Rockledge, Florida 32955

CERTIFICATE OF HMO COVERAGE

Please call 1.855.443.4735 for assistance regarding Claims and information about Coverage.

Employer Name:
Group Policy Number:
Group Policy Design:
Customer Service Number: **Toll Free 1.855.443.4735**

In accordance with the terms of the Group Policy issued to the Large Employer, Health First Commercial Plans, Inc. d/b/a Health First Health Plans (hereinafter called the "Health Plan") certifies that it will cover all eligible enrolled persons for the Services described in this Certificate of Coverage ("Certificate"). This Certificate replaces any and all Certificates and Riders previously issued.

The Health Plan will provide the Services described in this Certificate to Covered Employees and their Covered Dependents (hereinafter called "Insured" and/or "Covered Person(s)"), if any, on a direct-Service basis. This means that the Health Plan arranges or contracts with Physicians, Hospitals, or other Providers of medical care and employs administrative personnel to directly provide, organize, and arrange for such Service. The Health Plan agrees to use its best efforts to assure that its Providers render quality Health Care Services in conformity with accepted community medical standards. The Physicians, Hospitals, and Providers of medical care are not the Health Plan's agents, apparent agents, or employees, nor is the Health Plan their agent, apparent agent, or employee. Nothing contained in this Group Policy is intended to interfere with communication between Covered Persons and their Physicians, Hospitals, and Providers, and the Health Plan does not control the clinical judgment or treatment recommendation made by any Provider.

This Certificate describes the administrative details, Services, provisions, and limitations of the Group Policy. The Services outlined in this Certificate are effective only if a person is eligible for Coverage, becomes Covered, and remains Covered in accordance with the terms of this plan.

Any changes in this Certificate must be approved by an officer of the company and endorsed on the Certificate or attached to it. Any verbal promise made by an officer or employee of the company, or any other person, including an agent, will not be binding on the company unless it is contained in writing in this Certificate or an endorsement to it.

CEO
Health First Commercial Plans, Inc.

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I. INTRODUCTION TO YOUR CERTIFICATE OF COVERAGE

This Certificate and other Contract documents describe Your benefits, provisions of this Group Policy, as well as Your rights and responsibilities under the Contract. We encourage You to read Your Certificate and any attached Riders and/or amendments carefully. If there is a conflict between this Certificate and any summaries or other materials provided to You by the Health Plan or the Large Employer, this Certificate shall prevail. Please refer to Your Schedule of Benefits included in this Certificate to determine how much You have to pay for particular Health Care Services.

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.

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

II. ADMINISTRATIVE PROVISIONS

This section provides important information on the administration of this Group Policy, explaining:

- Who is eligible for benefits under this Group Policy, when Coverage becomes effective, when Coverage terminates, and what Covered Persons can do to continue Coverage upon termination;

- How this Group Policy will relate to other plans under which Covered Persons have Coverage or other situations where payment is made for the Services Covered under this Group Policy; and
- How Covered Persons can Appeal to the Health Plan upon disagreement of Coverage-based decisions.

A. ELIGIBILITY UNDER THIS GROUP POLICY

Because this Coverage is group Coverage, eligibility for Coverage is tied to the individual's relationship with the Large Employer that establishes this Group Policy. To be eligible for Coverage under this Group Policy, an individual must be either:

- An Eligible Employee of the Large Employer. An **Eligible Employee** is an individual who:
  - Works or has worked (if applicable) for the Large Employer on a full-time basis or part-time basis as defined by the Large Employer;
  - Has met any applicable Waiting Period requirements as defined by the Large Employer;
  - Is approved by the Health Plan; and
  - Lives or works in the Service Area, unless Covered under a Point-of-Service ("POS") plan.
- An Eligible Dependent of an Eligible Employee who resides in the Service Area, unless Covered under a POS plan. An **Eligible Dependent** means:
  - The Covered Employee's Spouse under a legally valid, existing marriage; and/or
  - The Covered Employee's Covered child who has not reached the end of the Calendar Year in which he or she reaches age twenty-six (26).
- A 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.

Unmarried children without dependents of their own 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:

- The child is a Florida resident or a full or part-time student; and
- The child is not provided Coverage under any other group, blanket, franchise health insurance plan, or individual health benefits plan, and 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 Group 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 Group Policy.

The term child includes the Covered Employee's natural born child, Newborn child, step child, or a Foster or legally Adopted child of the Covered Employee upon placement in the Covered Employee's residence, or at the birth of a Newborn Adopted child, where a written agreement to Adopt such child

has been entered into prior to the birth of the child. If the Foster or Adopted child is ultimately not placed in the residence of the Covered Employee, no benefit will apply.

The term also includes any child for whom the Covered Employee is the court-appointed legal guardian, a child who is dependent on the Covered Employee for health care Coverage pursuant to a Qualified Medical Child Support Order ("QMCSO"), or any child who lives with the Covered Employee in a normal parent-child relationship, if the child qualifies at all times for the dependent exemption, as defined in the Internal Revenue Code and Federal Tax Regulations.

NOTE: It is the sole responsibility of the Covered Employee 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 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

In the case of a dependent child with an intellectual or physical disability, such child is eligible to continue Coverage as a Covered Dependent beyond the limiting age described above 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 Employee or Covered Employee's Covered Spouse for support and maintenance.

The term support, as used in the above definition, includes an Eligible Dependent that is claimed as a dependent on the Covered Employee'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 Covered Employee 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 does not meet the requirements for extended eligibility.

OTHER REQUIREMENTS/RULES REGARDING ELIGIBILITY

- No individual whose Coverage with the Health Plans has been terminated for cause or any other reason listed in the Disenrollment for Cause provision within the **Termination Provisions** section below shall be eligible for Coverage 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 Covered Employee must notify Us as soon as possible when a Covered Dependent is no longer eligible for Coverage. 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, 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, 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 Covered Employee provide proof, which is acceptable to Us, of a Covered Dependent's continued eligibility for 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.
- Eligibility for Coverage under this Certificate is determined by the Health Plan's guidelines and is applicable to You and Your dependents. In determining eligibility for Coverage under this Certificate, We rely on the information requested from You prior to Your enrollment.
- Material Misrepresentations, omissions, concealment of facts, and incorrect statements made by the Applicant, Insured, or Covered Dependents which are discovered by the Health Plan, may prevent payment of benefits under this Certificate and may void this Certificate for the individual making the misrepresentation, omission, concealment of facts, or incorrect statement. Fraudulent misstatements discovered by the Health Plan at any time, may result in this Certificate being voided or Claims being denied for the individual making or responsible for the fraudulent misstatement.
- If, in applying for this Certificate or in enrolling Yourself or 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.

B. ENROLLMENT TIME FRAMES

Any individual who is not properly enrolled hereunder will not be Covered under this Certificate. We will have no obligation whatsoever to any individual who is not properly enrolled.

There are four (4) time periods that an Eligible Employee or Eligible Dependent can enroll in Coverage under this Group Policy:

- The **Initial Enrollment Period** is the period of time during which an employee or dependent is first eligible to enroll. It begins on an employee's or dependent's initial date of eligibility and ends thirty-one (31) days later.
- The **Open Enrollment Period ("OEP")** is an annual period defined by the Large Employer, during which:
    - If the Large Employer offers more than one (1) health plan option through the Health Plan, an employee may change to one (1) of the alternatives offered; and
    - Employees who decided not to enroll for Coverage under the Health Plan during the Initial Enrollment Period may now enroll themselves and their Eligible Dependents.
- A **Special Enrollment Period ("SEP")** of thirty-one (31) days is provided for special circumstances described in the SEP provision section.

- Within sixty (60) days of losing eligibility for Medicaid or a Children's Health Insurance Program (CHIP) or becoming eligible for Premium assistance under Medicaid or CHIP.

SPECIAL ENROLLMENT PERIOD ("SEP")

An Eligible Employee or Eligible Dependent may also request to enroll in this Group Policy outside of the Initial Enrollment and OEP if that individual, within the immediately preceding thirty-one (31) days, was Covered under another employer health benefit plan as an employee or dependent at the time he or she was initially eligible to enroll for Coverage under the Health Plan, and:

- Demonstrates that they lost Coverage due to a loss of eligibility under the prior plan as a result of: legal separation, divorce, death, loss of dependent status, termination of employment, reduction in the number of hours of employment, or termination of Coverage due to the termination of employer contributions toward such Coverage; and
- Requests enrollment within thirty-one (31) days after the termination of Coverage under the other employer health benefit plan.

In addition, an SEP will be extended to Covered Employees acquiring a dependent through marriage, birth, Adoption, or placement for Adoption even when other Coverage is not lost. Qualifying Events considered eligible for Special Enrollment provisions are defined by Section 125 of the Internal Revenue Code.

When Coverage is requested within thirty-one (31) days of the Qualifying Event or termination of other employer sponsored Coverage, enrollment will be allowed outside of the Initial Enrollment and OEP, with Coverage becoming effective on the date of the Qualifying Event or retroactively to the date Coverage terminated.

C. ENROLLMENT PROCEDURES

Eligible Employees that become Covered under this Group Policy will be referred to as "Insured". To become an Insured, the Eligible Employee must:

- Complete and submit, through their Large Employer, a request for Coverage using enrollment forms approved by the Health Plan within the eligibility period;
- Provide any additional information needed to determine eligibility, if requested by the Health Plan; and
- Agree to pay his or her portion of the required Premium, if required by the Large Employer.

Eligible Employees and Eligible Dependents that do not enroll within the Initial Enrollment Period must wait until the next OEP to enroll, unless they qualify earlier due to circumstances provided for under the SEP provision.

D. EFFECTIVE DATES

The Effective Date of an Insured under this Group Policy depends upon when they enroll, as described below:

- If the Insured is eligible for Coverage on the Group Effective Date, Coverage will be effective on the Group Effective Date;
- If the Insured becomes eligible after the Group Effective Date and enrolls during the Initial Enrollment Period, Coverage will be effective on the date the employee becomes eligible. This includes those new employees required to fulfill a Large Employer Waiting Period (see Waiting Period in the **Definitions** section of this Certificate);
- If the Insured qualifies and enrolls as a special enrollee, Coverage will become effective on the date of the Qualifying Event (i.e., marriage, birth, termination of other group Coverage, etc.); or

- If the Insured enrolls during OEP, Coverage will become effective on the Large Employer's Anniversary Date.

E. DEPENDENT ENROLLMENT

An individual may be added upon becoming an Eligible Dependent of a Covered Employee.

Newborn Child – To enroll a Newborn child who is an Eligible Dependent, You must submit, through Your Large Employer, a request for Coverage using enrollment forms approved by Us within the eligibility period. The following guidelines will be applied when enrolling a Newborn child:

- If We receive written notice within thirty-one (31) calendar days after the date of birth, the Effective Date of Coverage will be the date 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 thirty-two (32) to sixty (60) calendar days after the date of birth, the Effective Date of Coverage will be the date of birth, and the Premium will be charged from the date of birth; and
- If written notice of the birth is not given within sixty (60) days of birth, the Newborn child will be considered a late enrollee and ineligible to enroll for Coverage until the next annual OEP.

Newborn Child of a Covered Dependent Child – Coverage for such a Newborn child of a Covered family member, other than the Covered Employee's Spouse, will automatically terminate eighteen (18) months after the birth of the Newborn child. If a Newborn child is to be added to the Group 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, through Your Large Employer, a request for Coverage using enrollment forms approved by Us within the eligibility period. The Effective Date of Coverage for an Adopted Newborn child who is eligible for Coverage shall be the moment of birth, provided that timely notice is given and a written agreement to Adopt such child has been entered into by the Covered Employee prior to the birth of such child, whether or not such an agreement is enforceable. We may require You to provide any information and/or documents which We deem necessary in order to administer this provision. The following guidelines will be applied when enrolling an Adopted Newborn child:

- If We receive written notice within thirty-one (31) calendar days after the date of birth, the Effective Date of Coverage will be the date of birth, and no Premium will be charged for the first thirty-one (31) calendar days of Coverage for the Adopted Newborn child;
- If We receive written notice thirty-two (32) to sixty (60) calendar days after the date of birth, the Effective Date of Coverage will be the date of birth, and the Premium will be charged from the date of birth; and
- If notice is not given within sixty (60) calendar days of birth, the Adopted Newborn child will be considered a late enrollee and ineligible to enroll for Coverage until the next annual OEP.

For all children Covered as Adopted Newborn 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 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 18th birthday, You must submit, through Your Large Employer, a request for Coverage using enrollment forms approved by Us within the eligibility period immediately following the date of birth or placement. The Effective Date for an Adopted or Foster Child (other than an Adopted Newborn child) shall be the date such Adopted or Foster Child is placed in the Covered Employee's

residence pursuant to Florida law, provided that timely notice is given. We may require You to provide any information and/or documents deemed necessary by Us in order to properly administer this provision. The following guidelines will be applied when enrolling an Adopted or Foster Child:

- If the Adopted or Foster Child is enrolled within thirty-one (31) calendar days, the Effective Date of Coverage will be the date of placement in the Covered Employee's residence, and no Premium will be charged for the first thirty-one (31) calendar days of Coverage; and
- If the Adopted or Foster Child is enrolled within thirty-two (32) to sixty (60) calendar days, the Effective Date of Coverage will be the date of placement in the Covered Employee's residence, and the Premium will be charged from the date of placement. The Adopted or Foster Child will not be denied Coverage if notice is received within sixty (60) days of the birth or placement of the child.

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. Proof of final Adoption must be submitted to Us. It is Your responsibility to notify Us 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 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. Upon receipt of this notification, We will terminate the Coverage of the child on the first billing date following receipt of the written notice.

Marital Status – You may apply for Coverage for an Eligible Dependent Spouse due to marriage. To enroll a Spouse, You must submit, through Your Large Employer, a request for Coverage using enrollment forms approved by Us within the thirty-one (31) day period immediately following the date of marriage. If You apply for Coverage for an Eligible Dependent Spouse within thirty-one (31) 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 notice is not given within thirty-one (31) days, 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, through Your Large Employer, a request for Coverage using enrollment forms approved by Us. The Effective Date of Coverage for the Eligible Dependent shall be determined by Us.

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 file the required enrollment forms to Your Large Employer. 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.

F. TERMINATION PROVISIONS

Because this policy provides group Coverage, the continuation of the Coverage depends on the decisions of the Large Employer and on the Covered Employee's continued employment relationship to the Large Employer. The following sections explain when Coverage will end and the options available to the Insured to continue Coverage.

An Insured's Coverage under this Group Policy will end automatically at 11:59 p.m., Eastern Time, **[insert "on the date" or "on the last day of the month"]**:

- The contract between the Large Employer and the Health Plan terminates;

- The Insured's Coverage is terminated for cause (see the Termination of an Individual's Coverage for Cause provision below); or
- The Insured no longer meets eligibility requirements.

VOLUNTARY TERMINATION OF COVERAGE

An Insured may voluntarily terminate Coverage during the OEP by signing and submitting an Enrollment Change form to their Large Employer. This termination will be effective the first day of the first month following receipt of such Enrollment Change form. 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
  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 of benefits;
  - The knowing misrepresentation, omission, or the giving of false information to Us for the purpose of obtaining Coverage under this Certificate by You or on Your behalf;
  - Misuse of the ID card; or
  - The Covered Person's behavior is disruptive, unruly, abusive, unlawful, fraudulent, or uncooperative, to the extent that such Covered Person's continued Coverage in the Health Plan seriously impairs the Health Plan's ability to provide Coverage and/or arrange for the delivery of Health Care Services to the Insured. 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.

  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 Group Policy in its entirety.

- Leaving the Service Area
  Any Insured who leaves the Health Plan's Service Area with the intent to relocate or establish a new residence outside of the Service Area or any Insured who is absent from the Service Area for ninety (90) calendar days, is deemed to have left the Service Area and will no longer be eligible for Coverage under this Group Policy. The Insured is required to notify the Health Plan in writing if the Insured leaves the Service Area for the purpose of relocation. Coverage will continue through the end of the month in which the Insured relocates or is deemed to have left the Service Area so long as the required Premium is paid. To determine whether an Insured relocates or is deemed to have left the Service Area, We may request at any time that You provide Us written or electronic verification, acceptable to Us, of the Insured's primary residence within the Service Area.

- A Covered Dependent of the Insured reaches the limiting age under the Group Policy provided that the termination shall only apply to the Coverage of that dependent.
- Non-Payment of Group Policy Premiums
  If the Health Plan does not receive Premiums before the last day of the Grace Period, Coverage under this Group Policy will terminate as of the last day of the month for which Premium was paid. If Coverage is terminated for non-payment of Premium as set forth in this Group Policy, the Health Plan will mail the Large Employer a written notification that this Group Policy is terminating within five (5) business days of the date of termination. This notification will state the date of termination and the reason(s) for termination. It is the Large Employer's obligation to immediately notify each Insured of any such termination.

If an Insured'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. The Health Plan will state the reason(s) for termination.

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

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 policy or deny any Claim for loss incurred or disability starting after the two (2) year period.

RENEWAL CONDITIONS

Coverage under the Group Policy is for an initial term of twelve (12) months, commencing as of the Group Effective Date, and will automatically renew for successive terms of twelve (12) months unless terminated as provided for in the Group Policy. This Group Policy is guaranteed renewable. The Insured will remain in the plan selected the previous year unless a change is requested during the Large Employer's OEP. However, the Health Plan may refuse to renew this Group Policy and all Coverage provided for under this Certificate for any of the following reasons:

- Failure to timely pay Premium in accordance with the terms of the Group Policy;
- The Health Plan ceases offering this policy to all Insured;
- The Covered Employee or Covered Dependent has performed a Fraudulent Insurance Act or practice or made an intentional misrepresentation of material fact under the terms of this Certificate;
- The Covered Employee no longer permanently resides in the Health Plan's Service Area (unless enrolled in a POS Plan);
- Association membership ceases; or
- The Health Plan elects to discontinue all Large Group Coverage in the State of Florida.

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

days advance written notice. If the Health Plan ceases offering this Certificate to all Insured, the Health Plan will provide the Large Employer ninety (90) calendar days written notice prior to renewal and offer the option to purchase any other Coverage currently being marketed by the Health Plan in the Service Area. If the Health Plan discontinues offering all Large Group Coverage in Florida, the Health Plan will give the Large Employer one hundred and eighty (180) calendar days written notice prior to the Group Policy renewal date.

TERMINATION DATE OF A COVERED EMPLOYEE

A Covered Employee's Coverage will terminate at midnight, Eastern Time, on the date specified by the Health Plan in accordance with the Termination provisions described above.

TERMINATION OF A COVERED DEPENDENT

A Covered Dependent's Coverage will automatically terminate:

- At midnight, Eastern Time, on the date the Covered Employee's Coverage terminates for any reason;
- If the Covered Dependent fails to continue to meet any of the applicable eligibility requirements; or
- On the date We specify that the Covered Dependent's Coverage is terminated by Us for cause.

In the event the Covered Employee wishes to remove a Covered Dependent from Coverage, he or she must submit, through their Large Employer, an Enrollment Change Form prior to the required termination date. You may contact Your Large Employer to obtain the required form.

In the event the Covered Employee wishes to remove a Spouse from Coverage (e.g., in the case of divorce), he or she must submit, through their Large Employer, an Enrollment Change Form prior to the required termination date. You may contact Your Large Employer to obtain the required form.

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

In addition to the provision stated in the Termination of a Covered Dependent subsection, the Covered Spouse 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 Employee must notify Us within ten (10) calendar days of when the Spouse's eligibility requirements are no longer met or the Covered Spouse's death.

G. 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 the 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 procedure described in the **Claim Provisions** section of this Certificate.

H. CERTIFICATE OF CREDITABLE COVERAGE

The Certificate of Creditable Coverage provides evidence of an Insured's coverage that may be needed when applying for future health Coverage. The Certificate of Creditable Coverage will indicate who was Covered under the Group Policy and the period of time the Insured was enrolled

under the Group Policy. 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.

I. GROUP POLICY REPLACEMENT

If this Group Policy immediately replaces another group health plan, each Insured who was covered by the prior group health plan (e.g. employees, dependents, COBRA continuant, and Insured on sick leave, out ill, or on maternity leave) will be Covered by the Group Policy, including the Extension of Benefits rule described below, upon enrollment for this Group Policy.

J. EXTENSION OF BENEFITS

In the event this Group Policy is terminated in its entirety and a Covered Person is Totally Disabled on the date the Group Policy is terminated, the benefits described in the **Covered Services** section will be payable, subject to the regular benefit limits described in the **Covered Services** and **Exclusions and Limitations** sections, for expenses incurred due to the Sickness or Injury which caused such continuous total disability. This extension of benefits will cease on the earliest of:

- The date on which the continuous total disability ceases;
- The end of the twelve (12) month period immediately following the termination date of the Group Policy;
- The group secures replacement Coverage from another health care benefit plan that covers the Sickness or Injury causing the total disability; or
- The maximum benefits payable under the contract have been paid.

For pregnancy, Services directly related to the pregnancy will continue until the pregnancy ends, provided the pregnancy began after the Insured's Effective Date and prior to the termination of the Group Policy. This extension will not be based on total disability.

For the purposes of this section, "Continuous Total Disability" and "Totally Disabled" mean:

- For a Covered Employee, the person's inability to perform any work or occupation for which the person is reasonably qualified for or trained; or
- For a Covered Dependent, the person's inability to engage in most normal activities of a person of like age and sex in good health.

A Covered Person is not entitled to extension of benefits if Coverage is terminated for any of the following reasons:

- For cause, due to disruptive, unruly, abusive, or uncooperative behavior to the extent that such Insured's continued Coverage in the Group Policy impairs the Health Plan's ability to administer this policy or to arrange for the delivery of Health Care Services to such Insured;
- For fraud or intentional misrepresentation or omission in applying for any benefits under this Group Policy;
- For failure of the Large Employer to pay the required Premium; or
- For leaving the Health Plan's Service Area with the intent to relocate or establish a new permanent residence.

K. FEDERAL CONTINUATION OF COVERAGE PROVISIONS

The continuation of Coverage provisions described herein apply to Large Employers with twenty (20) or more employees**.**

Rights to continuation of Coverage under the federal law, Consolidated Omnibus Budget Reconciliation Act ("COBRA"), is applicable to Covered Persons upon termination as described below.

In order to be eligible for continuation Coverage under this federal law, the definition of a Qualified Beneficiary must be met. To be a Qualified Beneficiary, an individual must generally satisfy the following two (2) conditions:

- The individual must be a Covered Employee, the Spouse of a Covered Employee, or the Eligible Dependent child of a Covered Employee; and
- The individual must be Covered by a group health plan immediately before the Qualifying Event.

Qualifying Events are certain events that would cause an individual to lose health Coverage under a group health plan.

Types of Qualifying Events include:

- Termination of employment for any reason other than gross misconduct;
- Reduction in a Covered Employee's hours of employment;
- Death of the Covered Employee;
- Divorce or legal separation from the Covered Employee;
- Ceasing to be an Eligible Dependent under the terms of the Group Policy;
- The Covered Employee's entitlement to Medicare;
- Employer bankruptcy; and
- Loss of Dependent Status.

Every Qualified Beneficiary must be offered the opportunity to elect COBRA during the election period. A Qualified Beneficiary who has other group health plan Coverage or who is entitled to Medicare at the time of a COBRA election is entitled to elect COBRA and may choose to have dual Coverage for the entire COBRA Coverage period.

TYPE OF COBRA COVERAGE OFFERED

COBRA Coverage must be identical to the Coverage provided to similarly situated beneficiaries under the Health Plan under which a Qualified Beneficiary was Covered immediately prior to the Qualifying Event. However, if the Large Employer offers a POS plan, a Qualified Beneficiary may elect COBRA Coverage with the POS plan if the Qualified Beneficiary permanently relocates outside the Service Area of the Health Plan. Qualified Beneficiaries who are offered Health Maintenance Organization ("HMO") Coverage only by their Large Employer are not eligible to continue Coverage when permanently relocating outside the Service Area.

COBRA Qualified Beneficiaries may change Coverage during OEP under the same considerations as active employees. A Qualified Beneficiary may do the following things during Open Enrollment under the Health Plan, if a non-COBRA beneficiary is allowed to do so:

- Change benefit options or packages within the plan under which he or she was Covered prior to the Qualifying Event;
- Add Coverage for Eligible Dependents; and
- Switch to other group health plans offered by the Large Employer.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), employees who are eligible to participate in a group health plan have a special right to enroll certain family members upon the loss of other group health plan coverage or upon acquiring a new Spouse or dependent. Once a Qualified Beneficiary is receiving COBRA Coverage, the Qualified Beneficiary has the same right to enroll family members under the HIPAA rules as if the Qualified Beneficiary were an active employee or participant in the Health Plan. These rights are only available to Qualified Beneficiaries who timely elected COBRA and who are receiving COBRA continuation Coverage.

If the group's health Coverage for active employees changes, the COBRA Coverage for similarly situated Qualified Beneficiaries also changes accordingly.

LENGTH OF COBRA COVERAGE

COBRA continuation Coverage generally starts on the date of the Qualifying Event and may last through the maximum Coverage period, depending upon the type of Qualifying Event.

The following types of Qualifying Events have an eighteen (18) month maximum Coverage period:

- Terminations of employment; and
- Reductions in hours.

The following types of Qualifying Events have a thirty-six (36) month maximum Coverage period:

- The death of an employee;
- Divorce or legal separation of the employee;
- A child losing dependent status; and
- The employee becoming entitled to Medicare.

EXTENSION OF THE MAXIMUM COVERAGE PERIOD

A Qualified Beneficiary's maximum Coverage period can be extended under the multiple Qualifying Events or the disability extension rules described below. COBRA does not require that a Qualified Beneficiary be given notice of such an extension.

Multiple Qualifying Events

The eighteen (18) month maximum Coverage period for termination of employment or reduction in employment hours can be extended for multiple Qualifying Events, such as divorce commencing after the initial Qualifying Event of termination of employment. If, during the eighteen (18) month Coverage period, the Covered Employee dies, the Covered Employee divorces or legally separates, the Covered Employee becomes entitled to Medicare, or the Covered Employee's child ceases to be a dependent, the maximum Coverage period is extended to thirty-six (36) months, measured from the date that the eighteen (18) month period initially started.

Disability Extension

If all of the conditions listed below are met, then the maximum Coverage period for all Qualified Beneficiaries (including the employee) who became eligible for COBRA as a result of the same Qualifying Event is extended to twenty-nine (29) months. This is measured from the date that the eighteen (18) month period initially started.

- A Qualified Beneficiary is disabled (as determined by the Social Security Administration) on any day during the first sixty (60) days of COBRA continuation Coverage;
- The Qualifying Event was the reason for the Covered Employee's termination of employment or reduction in hours; and
- The Qualified Beneficiary notifies the plan administrator within sixty (60) days after the Social Security Administration's determination of disability and before the end of the original eighteen (18) month maximum Coverage period.

EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

The Health Plan can terminate a Qualified Beneficiary's COBRA Coverage before the maximum Coverage period (including any extension) expires if any one (1) of the following events occurs:

- The required Premium for the Qualified Beneficiary's Coverage is not paid on time (subject to COBRA Grace Periods);
- The Qualified Beneficiary becomes entitled to Medicare benefits after electing COBRA Coverage;

- The Qualified Beneficiary becomes covered by another group health plan after electing COBRA Coverage;
- The Large Employer ceases to maintain any group health plan for any employee;
- If the maximum Coverage period has been extended under the disability extension, the Qualified Beneficiary who had been determined to be disabled is determined not to be disabled (COBRA Coverage may be terminated for all Qualified Beneficiaries receiving extended COBRA Coverage under the disability extension); or
- For cause.

COVERAGE DURING COBRA ELECTION AND PREMIUM PAYMENT PERIODS

The Health Plan will not provide COBRA Coverage to a Qualified Beneficiary until a timely election is made and required Premiums are paid. Once COBRA Coverage is elected and Premiums are paid, COBRA Coverage will be reinstated back to the date of termination.

COBRA ELECTION PROCESS

The COBRA election process begins with a notice to the plan administrator that a Qualifying Event has occurred. The Large Employer has the obligation to notify the plan administrator when a Qualified Beneficiary loses or will lose Coverage due to: termination or reduction in hours of a Covered Employee's employment, death of the Covered Employee, the Covered Employee becoming entitled to Medicare, or the Large Employer's bankruptcy. The plan administrator must be notified within thirty (30) days of the Qualifying Event. In the case of divorce or legal separation or a child's ceasing to be Covered as a dependent under plan rules, the participant or Qualified Beneficiary must notify the plan administrator within sixty (60) days of the Qualifying Event. The plan administrator then has fourteen (14) days after receiving a Qualifying Event notice to notify each Qualified Beneficiary of his or her rights under COBRA.

COBRA continuation is not automatic. A Qualified Beneficiary must affirmatively elect COBRA Coverage within sixty (60) days of the date the plan administrator provides the COBRA election notice by returning a written election to the plan administrator. Each Qualified Beneficiary has an independent right to elect COBRA Coverage.

The Trade Act of 2002 amended COBRA to create a special second sixty (60) day election period for certain workers who did not elect COBRA Coverage during the regular sixty (60) day election period. This special second election period is available only in limited circumstances for certain individuals who have been affected by import competition or shifts abroad of production capacity and who are receiving trade adjustment assistance under the Trade Act of 1974.

COBRA PREMIUM

The COBRA Premium for a month's Coverage will be one hundred and two percent (102%) of the applicable plan Premium. There is an exception for Coverage for a disabled Qualified Beneficiary during the disability extension in which the COBRA Premium will be one hundred and fifty percent (150%) of the applicable plan Premium during the disability extension period.

Payment for the initial Premium is due no later than forty-five (45) days after the Qualified Beneficiary elects COBRA. Subsequent Premiums are due on the first day of each month, subject to a thirty (30) calendar day Grace Period. A Premium payment is considered a shortfall and will be considered as non-payment of Premium if the amount owed is greater than fifty dollars ($50) or ten percent (10%) of the outstanding COBRA Premium.

Note: Additional information pertaining to COBRA is available from the United States Department of Labor.

L. THE CONVERSION PRIVILEGE

A Covered Employee, who has been continuously Covered for at least three (3) months under this Group Policy and/or under another group plan providing similar benefits in effect immediately prior to this Group Policy, has the right to apply for a conversion plan if Coverage terminates due to the Covered Employee's:

- Termination of employment;
- Termination of the Covered Employee's Covered Membership in an eligible class; or
- Loss of Coverage due to the termination of this Group Policy, if it is not replaced by another health care plan within thirty-one (31) days of termination.

A Covered Employee's dependents that are Covered as dependents under this Group Policy may also convert, but only as dependents of the Covered Employee, not on their own. However, when a Covered Employee's dependents have been Covered for three (3) consecutive months before Coverage ends, they may, on their own, convert to a conversion plan under one (1) of the following conditions:

- If the Covered Employee's conversion Coverage terminates, Covered Dependents may convert under a new conversion plan;
- If the Covered Spouse is no longer an Eligible Dependent as defined in this Group Policy, the Spouse may convert; or
- If a Covered Dependent child is no longer an Eligible Dependent as defined in this Group Policy, such dependent may convert.

At the time of application, the eligible Insured will be offered a choice of at least two (2) plans. The new Coverage will be issued at rates not to exceed two-hundred percent (200%) of the Standard Risk Rate as determined and published by the Florida Office of Insurance Regulation ("OIR").

REQUESTING CONVERSION

An Insured who is eligible for conversion may obtain conversion Coverage without having to submit evidence of health qualification. The Insured must apply in writing and pay the first month's Premium for the conversion plan within sixty-three (63) days after his or her Coverage under this Group Policy terminates. The application form for use and information about conversion benefits may be obtained from the Health Plan.

If the Large Employer qualifies for federal continuation benefits described in the **Federal Continuation of Coverage Provisions** section above, conversion must not take place until the exhaustion of the federal continuation period.

Unless otherwise prohibited by law, conversion is not available if:

- The Insured commits fraud or misrepresentation in the application for conversion Coverage;
- The Insured has not been continuously Covered for at least three (3) months under this Group Policy and/or under another group plan providing similar benefits maintained by the Large Employer, in effect, immediately prior to the termination of this Group Policy;
- The Insured is Covered for similar benefits by another Hospital, surgical, medical, or major medical expense insurance policy, Hospital or medical service subscriber contract or medical practice, other prepayment plan, or by another plan or program;
- The Insured is eligible for similar benefits, whether or not actually provided coverage, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis;
- Similar benefits are provided for or are available to the Insured under any state or federal law;
- This Group Policy is replaced by similar group coverage within thirty-one (31) days of the termination date of this Group Policy;

- Federal Continuation Coverage, if available or had been available, has not been elected or exhausted;
- The Insured has been disenrolled for cause. The Health Plan may disenroll an Insured for cause if the Insured's behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her continuing membership seriously impairs Our ability to furnish Services to other Covered Persons;
- The Insured has left the Health Plan's Service Area with the intent to relocate or establish a new permanent residence; or
- Coverage under this Group Policy ends due to failure to pay any required Premium or contribution, unless such nonpayment of Premium was due to acts of a Large Employer or person other than the individual.

M. DISCRETIONARY AUTHORITY

The Health Plan has the sole 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 and is not required to provide notice or obtain approval from the Insured or Large Employer.

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.

N. CONFORMITY WITH STATE STATUTES

The validity, construction, and interpretation of this Certificate shall be governed by the laws of the State of Florida to the extent there is no conflict with applicable federal law and regulations with respect to an Employee Retirement Income Security Act of 1974 ("ERISA") Regulated Plan.

Any provision of this Group Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

III. COVERAGE PROVISIONS

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

- What guidelines Covered Persons 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 by, 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.

Usually, 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. 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.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS ON THE INSURED. 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 Group Policy, 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 Group Policy described herein.

We are not obligated to Cover or pay for any Service that has not actually been rendered to You.

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, 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. Coverage access guidelines may differ with a POS plan.

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

Under Your Group 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 any person 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 Specialists and Participating Facilities within Your Health Plan Provider Network. Covered Persons are free to choose any PCP from the published list of PCPs whose practices are open to new patients. PCPs may be Medical Doctors ("M.D.") or Doctors of Osteopathy ("D.O."). Each female Covered Person may select as her 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 the Covered Person 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 Medically Necessary Services. The Covered Person should look to the PCP to direct his/her care and should consider procedures and/or treatment recommended by the PCP.

B. ACCESSING SPECIALTY CARE

Whether enrolled in an HMO or POS plan, 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 who have not been referred for care by their PCP. In these instances, Covered Persons will first need to see a PCP. Although the Health Plan operates as an "Open Access" HMO, We strongly recommended 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 got the care within the Participating Provider Network. Please contact Your PCP to help coordinate these Services.

POS Covered Persons who elect to receive treatment from a non-participating Specialist will pay the Out-of-Network Cost-Share.

For HMO Covered Persons, 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.

C. CONTINUITY OF CARE

If a Participating Provider terminates his or her contract 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 (as long as the terminated Provider agrees to continue treating the patient at the contracted reimbursement rate) 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, such 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 Group Policy to ensure proper Coverage.

A Provider (PCP or Specialist) may refuse to continue to provide 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 HMO Covered Persons in order for the Services to be Covered by the Health Plan.

D. 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 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. 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.

More than one (1) Cost-Share may apply to Services provided in an emergency room setting. For example, some plans include a Cost-Share for the emergent visit and separate Cost-Shares for additional Services, such as advanced imaging, if applicable. See Your Schedule of Benefits for details.

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 for HMO Covered Persons.

All follow-up care must be coordinated and authorized according to the provisions of this Group 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 lesser of:

- The Provider's charges;
- The usual and customary Provider charges for similar Services in the community where the Services were provided; or
- The charge mutually agreed to by the Health Plan and the Provider within sixty (60) days of the Claim submittal.

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

This Certificate also Covers Emergency Services outside the United States and its territories up to the Medicare Allowed Amount in the Health Plan 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 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.

Covered Persons enrolled in an HMO Plan should always try to obtain Urgent Care from Network Providers. However, if Providers are temporarily unavailable or inaccessible, and it is not reasonable to wait to obtain care from a Network Provider, the Health Plan will Cover Urgent Care received from an Out-of-Network Provider. For HMO Covered Persons, Coverage outside the Network is also 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.

E. PRIOR AUTHORIZATION

In order for certain Services to be Covered, prior approval by the Health Plan is required. This provision includes Services such as Inpatient care, diagnostic, and medical procedures, certain pharmaceutical Services (for a Group Policy that includes a Prescription Drug Rider), and all Out-of-Network Services (except for Emergency Medical Conditions or Urgent Care) received by HMO Covered Persons. If Services requiring Prior Authorization are obtained without proper Authorization, the Covered Person may be responsible for their entire cost. Services requiring Prior Authorization are subject to change without prior notice and at the sole discretion of the Health Plan. A current list of Covered Services requiring Prior Authorization are posted on the Health Plan's website at myHFHP.org.

When Prior Authorization is required, the Provider must submit the 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 Provider, who will communicate with the Covered Person. If Authorization is denied for any reason, both the Covered Person and the requesting Provider will receive a notice explaining the reason for the denial and the process for filing an Appeal.

Covered Persons Covered under a POS plan who utilize their Out-of-Network benefits for non-Emergency Services or non-Urgent Care bear an additional responsibility of ensuring that any Out-of-Network Providers who may not be familiar with the Health Plan's Authorization requirements secure the appropriate Authorizations prior to receiving care.

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.

CONCURRENT CARE

If ongoing care has been approved over a period of time or in a specified number of treatments, and the Covered Person or treating Provider wishes to extend the course of treatment, the Covered Person, through their treating Provider, must request the Health Plan to continue the ongoing care at least twenty-four (24) hours prior to the end of the approved course of treatment.

Standard concurrent care decisions will be made and the treating Provider and Covered Person will be notified within seventy-two (72) hours. Expedited concurrent care decisions will be made and the treating Provider and Covered Person will be notified within twenty-four (24) hours of the Health Plan receiving the request. The Health Plan may extend the expedited concurrent care decision time frame by an additional forty-eight (48) hours, allowing up to seventy-two (72) hours to render a decision. Such extension may be provided when:

- A request to extend the expedited concurrent care was made within the original twenty-four (24) hour decision time frame;
- The request is related to care not previously approved for the Covered Person by the Health Plan, and the Health Plan documents that it made at least one (1) attempt to obtain the necessary clinical information, but was unsuccessful, within the initial twenty-four (24) hours of the request; and
- The Covered Person voluntarily agrees to extend the decision-making time frame.

F. MEDICAL PAYMENT GUIDELINES FOR NON-PARTICIPATING PROVIDER CARE

If a Covered Person requires care from a Provider type that the Health Plan does not have under contract, arrangements will be made by the Health Plan to provide the appropriate care elsewhere. These Services will be Covered under the In-Network level of benefits for both HMO and POS Covered Persons provided that such Services are authorized and approved as such in advance by the Health Plan.

If the HMO Covered Person requires care from a Non-Participating Provider, and such care has been authorized in advance when required by the Health Plan, the Health Plan's payment for Covered Services will be limited by the Medical Payment Guidelines then in effect. 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 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.

G. POS GUIDELINES FOR OUT-OF-NETWORK COVERED SERVICES & BENEFITS

These provisions apply to POS plans that may be purchased by the Large Employer at an additional expense. The attached Schedule of Benefits will identify whether or not You have a traditional HMO benefit plan or a more flexible POS benefit plan. POS plans allow Covered Persons to seek the specified Covered Services from Participating and Non-Participating Providers. A higher Cost-Share is typically associated with seeking care from Non-Participating Providers, as well as exposure to expenses above the Health Plan's Allowable Fee Schedule.

ACCESS

Covered Employees and their Covered Dependents are encouraged to select a PCP but are not required to do so. A Covered Person Covered under a POS plan may choose to self-refer to a Provider who is not participating with the Health Plan or to a Participating Provider for Covered Services and supplies. Service limits and benefit maximums are calculated by using the sum total of benefits and Services provided both In-Network and Out-of-Network. For example, a visit In-Network and another visit for the same Service Out-of-Network, would count as two (2) visits towards any applicable Service limit.

FINANCIAL RESPONSIBILITY

In general, when a Covered Person receives Covered Services, the Covered Person's financial responsibility is any applicable Deductible, Copayment, or Coinsurance. Payment may be required at the time Services are rendered. A Covered Person is responsible for satisfying the Calendar Year Deductible, if applicable, before the Coinsurance applies. For a POS Covered Person, any amount in excess of the Allowable Fee Schedule that is charged by a Non-Participating Provider who has not entered into an agreement with the Health Plan to provide access at a discount, is the sole responsibility of the Covered Person. This amount will not apply towards satisfaction of the Calendar Year Deductible or Out-of-Pocket Maximum Calendar Year Expense Limit. When the Out-of-Pocket Maximum Expense Limit is satisfied, the POS Covered Person will continue to be responsible for any charges in excess of the Allowable Fee Schedule for Non-Participating Providers. When seeking Out-of-Network Services, Covered Persons are encouraged to negotiate acceptance of the Health Plan's Allowable Fee Schedule in advance of seeking treatment in order to lower their out-of-pocket costs.

MEDICAL NECESSITY

All Services and supplies Covered under the Out-of-Network benefits must be Medically Necessary as defined in the Group Policy. Some Services and supplies require approval by the Health Plan prior to the Services being rendered.

PRIOR AUTHORIZATION FOR COVERED SERVICES

In order to determine whether Services and supplies are Medically Necessary, certain Services and supplies require approval from the Health Plan in advance of the Services or supplies being received. Under the Out-of-Network benefits section, the Covered Person is ultimately held responsible for making sure Services and supplies have been approved by the Health Plan in advance of receiving them. The Covered Person will be responsible for the cost of Services and supplies if Prior Authorization is required but not obtained, regardless of whether such Services or supplies are deemed Medically Necessary.

Services and supplies that require Prior Authorization are detailed in the Health Plan's Authorization List, available on the Health Plan's website at myHFHP.org or by contacting the Customer Service Department at 1.855.443.4735. The Authorization List is updated at least annually but is subject to change, at the Health Plan's discretion, without notice.

IV. COVERED SERVICES

This section describes the Services and supplies that are Covered under this Group 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 and any Riders attached to this Certificate.

You should read all of these provisions carefully to understand the benefits provided under this Certificate.

The Services and supplies listed below will be considered Covered Services under this Group 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 Directory, except for Urgent or Emergency Services and Care, unless the Covered Person is enrolled in a POS plan;
- Actually rendered while Coverage under this Group 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. The payment of expenses for Covered Services received from Non-Participating Providers is subject to the Health Plan's Allowable Fee Schedule (see the **Definitions** section of this Certificate).

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 as set forth in the Schedule of Benefits.

Alcohol and Substance Abuse Treatment
Alcohol and substance abuse 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 substance abuse 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.

Prior Authorization is required after fifteen (15) Drug test Services.

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 by boat, airplane, or helicopter are Covered as described above, and will be reimbursed at the Allowed Amount level for a ground vehicle 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 furnished 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
Coverage for autism 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 Autism Spectrum Disorder by eight (8) years of age or younger. 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.

Coverage for outpatient ST, OT, and PT to treat Autism Spectrum Disorder is limited to twenty (20) visits per Calendar Year for each type of therapy Covered. 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.

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. In addition, prostate cancer screening (e.g., prostate specific antigen ("PSA") test) is Covered without Cost-Sharing for adults fifty (50) years of age or older. Skin cancer screenings are Covered with applicable Cost-Sharing amounts. Frequency 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.

Child Cleft Lip and Cleft Palate Treatment
Health Care Services for child cleft lip and cleft palate, including medical, dental (that are not Covered under the Insured's dental plan), ST, audiology, and nutrition Services, for treatment of a child eighteen (18) years of age or under who has cleft lip or cleft palate, are Covered when considered Medically Necessary and 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.

Chimeric Antigen Receptor, T cell (CAR-T) Therapy
CAR-T Cell Therapy is Covered for FDA Approved uses.

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 developmental 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 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 dental care provided to You in a Hospital or Ambulatory Surgical Center if:
    - A Covered Dependent under eight (8) years of age whose 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 proved to be ineffective; or
    - A Covered Person who 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 Medically Necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

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.

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 by the Health Plan.

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 as Preventive with no Cost-Share 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, is 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 defined in this **Covered Services** section.

Dialysis Services
Dialysis Services, including hemodialysis and peritoneal dialysis, are Covered, and include equipment, training, and medical supplies required for home dialysis or when provided on an outpatient basis (e.g., at a 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.

Coverage for outpatient ST, OT, and PT to treat Down Syndrome is limited to twenty (20) visits per Calendar Year for each type of therapy Covered. 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 Group Policy. The specified DME will not be Covered, in whole or in part, when it serves as a comfort or convenience item for the Covered Person or is 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 which 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.

Certain DME requires Prior Authorization by the Health Plan.

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 the need for any Prior Authorization.

When Emergency Services for an Emergency Medical Condition are provided by an Out-of-Network Provider, any Cost-Share amount applicable to In-Network Providers for Emergency Services will also apply to the Out-of-Network Provider.

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

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 through the age of twenty-four (24) years with inborn errors of metabolism or inherited metabolic diseases, which includes phenylketonuria ("PKU"). Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein**.** 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 **Prescription Drugs (Outpatient)** section of this document.

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

- Contraceptive methods approved by the U.S. Food and Drug Administration ("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 contraceptive items when prescribed by a Physician.

Note: Vasectomies are only Covered as a Preventive benefit when performed in a Physician's office. Vasectomies performed outside of a Physician's office are subject to Cost-Sharing.

Fitness Center Membership
Fitness center membership is Covered to assist all Covered Persons with maintaining or improving their health status. The Health Plans offers a fitness center membership to the Insured and their Covered Dependents exclusively at fitness centers contracted as Participating Providers. 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. Membership to the Pro Health and Fitness Centers is offered to Covered Persons twelve (12) years of age and older. Age limitations may apply for other participating fitness centers.

Genetic and Chromosomal Testing and Counseling
Genetic and chromosomal testing and counseling are 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 Covered Person 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 impact 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. When prescribed in

conjunction with a Medically Necessary genetic test, Genetic Counseling will be Medically Necessary before and after the test when conducted by a Physician or certified genetic counselor.

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 furnished 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 and the assistance of another person because You are bedridden or chair bound, You are restricted in ambulation (whether or not You use assistive devices), or You are 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 three (3) intermittent visits per day provided by a Participating Home Health Agency. One (1) visit equals a period of four (4) hours or less;
- A total of sixty (60) visits per Calendar Year as set forth in the Schedule of Benefits;
- Home health aide Services which are 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; 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 plan 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
- Physical, Occupational, and Speech Therapy 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 doctor 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 furnished to a Covered Person at a Hospital on an Inpatient or outpatient basis in accordance with all other plan provisions included herein. 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 patient 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;
- Physical, Speech, Occupational, 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 advance by the Health Plan. For a Group Policy with an attached Prescription Drug Rider, please see the Formulary for Covered Prescription Drugs. Refer to **the Prescription Drugs (Outpatient)** section of this document.

Imaging Services
Covered imaging Services include standard radiology Services and advanced (high-end) imaging, including CT scans, Magnetic Resonance Imaging ("MRI"), Magnetic Resonance Angiography ("MRA"), Positron Emission Tomography ("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 **Prescription Drugs (Outpatient)** 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:

- 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;
- A baseline mammogram for any woman who is between thirty-five (35) and 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;
- 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 30 (subject to Cost-Share); or

- 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 postsurgical follow-up in accordance with prevailing medical standards, as determined by the Covered Person and the Covered Person's attending Physician, are Covered. Outpatient postsurgical 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, and Mental Health Professionals, which includes clinical social workers, marriage and family therapists, or mental health counselors, 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 are 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 are Covered as Preventive Health Services.

Obstetrical and Maternity Care
Obstetrical and maternity care received on an Inpatient or outpatient basis is Covered, including Medically Necessary prenatal and postnatal care of the mother and baby. Up to fifteen (15) prenatal office visits per Calendar Year are Covered as a Preventive benefit, in addition to Preventive care and screenings for women that are provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"). Prenatal Preventive Coverage does not extend to perinatology Services. Perinatologist visits are subject to the Specialist office visit Cost-Share 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.

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.

Prepared childbirth classes are Covered up to seventy-five dollars ($75) per Calendar Year. To be reimbursed for Covered Services, follow the reimbursement process outlined in this Certificate.

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 once every two (2) years and is not subject to Cost-Share, when rendered by a Participating Provider, as set forth in the Schedule of Benefits.

Outpatient Habilitation Services
The therapies described below are Covered when provided to treat Autism or Down Syndrome:

- 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 twenty (20) visits per type of therapy, per Calendar Year, for each Condition being treated. All therapy Services must be considered Medically Necessary by the Health Plan and require Authorization in advance.

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, 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 twenty (20) visits per type of therapy, 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.

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, Outpatient Habilitation Services, and SNF Services categories in this section.

Oxygen

Covered oxygen Services include the expenses for oxygen and 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 5-year supplier obligation period starts once the old 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.

Pap Smears
Pap smears are Covered as a Preventive Health Service when performed as recommended by the USPSTF or in accordance with 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.

Physician Services
Covered Services include Medically Necessary medical or surgery Services furnished 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 any person 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, 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.

This benefit does not include allergy injections. Allergy injections are Covered, subject to the Allergy Testing and Immunotherapy Cost-Share set forth in the Schedule of Benefits attached to this Certificate.

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 which would preclude performing the procedure.

Prescription Drugs (Outpatient)
Outpatient Prescription Drugs included in the Formulary are Covered if a Prescription Drug Rider is attached to this Certificate. 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. The Rider describes in detail the Coverage provided therein, and the Health Plan retains the right to modify the Rider.

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 a Insured's Health Savings Account ("HSA"), or modifications to Copayment, Deductible, or Coinsurance amounts.

Prosthetic Devices (External)
Prosthetic Devices are Covered when considered Medically Necessary, 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 such 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 when there is 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.

Routine Costs Associated with 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 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 Authorization in advance; and
- When received from Participating Providers or Non-Participating Providers when required in order to participate in the trial. Coverage for items or Services obtained from Non-Participating Providers is limited to the Health Plans' Allowable Fee Schedule. Covered Persons Covered under an HMO Group Policy 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.

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;
- For Covered Persons enrolled in an HMO Group Policy, 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
Self-administered Prescription Drugs are Covered if a Prescription Drug Rider is attached to this Certificate. Such Coverage 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.

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 is limited to one-hundred and twenty (120) 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 Chapter 651 of the 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** section of this Certificate.

Sleep-Related Disorders Testing and Treatment
Sleep-related disorder testing and treatment, including sleep studies, Positive Airway Pressure ("PAP") devices, and sleeping agents listed in the Formulary for a Group Policy with an attached Prescription Drug Rider, 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. Coverage is limited to eight (8) sessions per Calendar Year for Covered Persons who use tobacco.

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 (20) spinal manipulations per Calendar Year; and
- Payment for Covered PT Services rendered on the same day as spinal manipulation is limited to one (1) PT treatment per day, not to exceed fifteen (15) minutes in length.

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, including 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 Covered as a Preventive benefit when performed in a Physician office setting;
- Surgery to correct deformity which 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 American Medical Association ("AMA") 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 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.

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);
- 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 Statute. 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; and

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 Group 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 Group 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 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 age eighteen (18));
- 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 age eighteen (18)) 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 per Calendar Year for Covered Persons diagnosed with diabetes. Refer to the Schedule of Benefits for applicable Cost-Share.

Additional Coverage for vision Services and materials may be Covered if a Vision Rider is attached to this Certificate.

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 obstetrician's/gynecologist's 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 AND LIMITATIONS

A. ACCESS RULES

If a Covered Person does not follow the rules for accessing Services and supplies as described in this section, the Covered Person risks having the Services and supplies received not Covered by this Group 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 Urgent Care, all Services and supplies must be received from Participating Providers, unless Covered under a POS Plan. It is the Covered Person's responsibility to verify the participation status of the Provider.

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 a Covered Service or Medically Necessary. Whether a Service is a Covered Service is

determined according to the terms of the Group 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 Group 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.

Alcohol or Drug-Related Injuries

Alcohol or Drug-related Injuries, when sustained as a result of being under the influence of alcohol, an intoxicant, an illegal substance, or a narcotic not taken upon the advice of a Physician, are excluded from Coverage.

Alternative Medical Treatments

Alternative medical treatments are excluded from Coverage. Examples of alternative medical treatments include:

- 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) for the treatment of severe diabetic foot disease, are excluded from Coverage.

Assisted Reproductive Therapy (Infertility)
Assisted reproductive therapy is excluded from Coverage. Examples of assisted reproductive therapy include 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.

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
For a POS Covered Person receiving Services or supplies 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, charges, expenses or costs in excess of the Health Plan's Allowed Amount for Covered Services are the sole responsibility of the Covered Person and 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), which includes 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 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
Dental treatment in a Hospital or Ambulatory Surgical Center, for children under age nineteen (19) due to cleft palate or cleft lip, or in preparation for radiation treatment, renal transplantation, or heart valve replacement surgery are Covered as specified in the **Covered Services** section. All other dental procedures are excluded from Coverage, including 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, dental x-rays, and intra-oral surgical procedures.

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.

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

Developmental Delay Treatment
Developmental delay treatment, including Services and supplies necessary to improve the motor, language, social, or thinking skills of a Covered Dependent child who does not reach their developmental milestones at expected times, is excluded from Coverage. This exclusion does not include Services for the treatment of Autism Spectrum Disorder or Down Syndrome, as set forth in the **Covered Services** section of this Certificate.

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, is 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 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.

Foot Care
Routine foot care, including any Service or supply in connection with foot care in the absence of disease, is excluded from Coverage. Examples of foot care include non-surgical treatment of bunions, flat feet, fallen arches, and chronic foot strain, toenail trimming, corns, or calluses. This exclusion does not apply to Services otherwise Covered under the Diabetes Outpatient Self-Management 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
Immunizations 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 the inability to achieve conception or the inability to maintain a pregnancy, are excluded from Coverage. This exclusion includes the medications clomiphene citrate ("Clomid"), AI, IVF, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, 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 except as specifically provided for in the Covered Services section of this Certificate or is listed on the Formulary under any applicable Prescription Drug Rider, unless approved by the Health Plan in advance.

Learning and Developmental Services
Testing, therapy, or treatment for reading and learning disabilities are excluded from Coverage, with the exception of the Autism Spectrum Disorder and Down Syndrome categories in the **Covered Services** section of this Certificate. 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 health Services.

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. This includes 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 furnished in a Physician's or a dentist's office or other less costly setting.

Non-Participating Provider Services for HMO Covered Persons
For a Covered Person Covered under an HMO plan, 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 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 is excluded from Coverage. This exclusion does not include Services described in the Obesity Treatment category of the **Covered Services** section of this Certificate. If Your Large Employer has opted to include the bariatric Rider, please see the attached Rider document for Coverage details.

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, intra-partal (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
Expenses in connection with any Condition for which a Covered Person has received, or is entitled 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 Group 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 for 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) for the treatment of diabetics with severe vascular disease, deformities, 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).

Oversight of a Medical Laboratory by a Physician or Other Health Care Provider
"Oversight", as used in this exclusion, shall include the oversight of:

- The laboratory to assure timeliness, reliability, and/or usefulness of test results;
- The calibration of laboratory machines or testing of laboratory equipment;
- The preparation, review, or updating of any protocol or procedure created or reviewed by a Physician or other Health Care Provider in connection with the operation of the laboratory; and
- The laboratory equipment or laboratory personnel for any reason. Other medical director duties performed in furtherance of, and set forth within the Clinical Laboratory Improvement Amendments ("CLIA").

Over-the-Counter ("OTC") Items
Supplies that can be 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 deemed to be not Medically Necessary and not directly related to the treatment of the Covered Person 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 (except as set forth in the **Covered Services** section of this Certificate, are excluded from Coverage);
- 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.

Prescription Drugs
Prescription Drugs, including any outpatient Prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods, are excluded from Coverage, unless a Prescription Drug Rider is attached to this Certificate. When applicable, the Rider will describe in detail the Coverage provided therein, and the Health Plan retains the right to modify the Rider.

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 that are:
- Determined to be not Medically Necessary;
- Not appropriately documented and/or substantiated in a corresponding medical record;
- Not specifically listed in the **Covered Services** section of this Certificate, unless such Services are specifically required to be Covered by Florida or 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 under this Group 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;
    - Services 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 Group Policy, unless Coverage is extended in accordance with the **Extension of Benefits** provision in 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 the Large 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. This exclusion includes any Service or supply related to such treatment, including psychiatric Services and Prescription Drugs.

Skilled Nursing Facilities ("SNF")
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.

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

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, body building, 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, pulmonary, Speech, Occupational, and Physical Therapy, 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 are excluded from Coverage. Examples of training and educational programs and materials include materials for Pain Management, vision training, or vocational rehabilitation, except as provided for under the Diabetes Outpatient Self-Management and Maternity categories of the **Covered Services** section of this Certificate.

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 Statutes; 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 in the Florida Administrative Code or any successor or similar rule or Covered by Medicare pursuant to a national Coverage decision made by the Centers for Medicare & Medicaid Services ("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 and Vacation Expenses
Travel and vacation expenses, even if prescribed or ordered by a Provider, are excluded from Coverage.

Vision Services and Supplies
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, eye glasses, 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 category of the **Covered Services** section of this Certificate or vision Services or materials that may be Covered under an

attached Vision Rider. When applicable, the Rider will describe in detail the Coverage provided therein, and the Health Plan retains the right to modify the Rider.

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

Weight Control Services
Weight control Services, except for Physician counseling Services, as well as any agent when used for anorexia, weight loss, or weight gain (except Prescription Drug products being used to treat acquired immunodeficiency syndrome (AIDS) wasting and cachexia), are excluded from Coverage. Examples of weight control Services include 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.

Work-Related Condition Services
Work-Related Condition Services, to treat a work related Condition to the extent the Covered Service is paid by Workers' Compensation through adjudication or settlement, or when the Services would otherwise be eligible for Coverage by Workers' Compensation insurance, but were not claimed, 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, any Rider or Endorsement attached hereto, 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 Section 877 of the Florida Statutes, or any substance controlled under Chapter 893 of the Florida Statutes (or, with respect to such statutory provisions, any successor statutory provisions). 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;
- 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 misdemeanor or 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 at military or government facilities;
- 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; and
- Services that are not patient-specific or generalized, 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 the Large Employer, mutual association, labor union, trust, or similar person or group.

D. ADDITIONAL EXCLUSIONS AND LIMITATIONS FOR A POS GROUP POLICY

- Services and supplies that are not Medically Necessary are not Covered, except for Preventive Health Services and care as outlined in the **Covered Services** section of this Certificate; and
- When Services and supplies are received from Non-Participating Providers, charges in excess of the Allowable Fee Schedule are the sole responsibility of the Covered person. It is Your responsibility to verify the participation status of the rendering Provider. Please refer to the Schedule of Benefits for Cost-Sharing.

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. THE CALENDAR YEAR DEDUCTIBLE

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. 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 Group 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 Group 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;
- Prescription Drug expenses, unless the Group Policy includes integrated Prescription Drug Coverage. (Note: A Prescription Drug Rider may include a separate Prescription Drug Deductible that must be satisfied each Calendar Year. If applicable, this separate Deductible will be stated on the Rider attached to this Certificate.); and
- Pharmaceutical manufacturer sponsored patient assistance programs (“PAPs”) do not count towards the Calendar Year Deductible.

INDIVIDUAL CALENDAR YEAR DEDUCTIBLE

This amount, when applicable, must be satisfied by each Covered Person every 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 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 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 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 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, Covered family members must meet the combined family Calendar Year Deductible before any benefits subject to the Deductible are payable by the Health Plan.

Note: For POS plans, the Out-of-Network Calendar Year Deductible shown on Your Schedule of Benefits is separate from Your In-Network Deductible. Expenses applied toward Your Out-of-Network Deductible are not applied to Your In-Network Deductible. Expenses applied toward Your In-Network Deductible are not applied to Your Out-of-Network Deductible.

B. COPAYMENTS

For some Covered Services, Covered Persons are 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 Group Policy are set forth in the Schedule of Benefits.

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 Group Policy, must be satisfied by You for each Inpatient admission to a Hospital or Psychiatric Facility before any payment will be made by Us 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 Group Policy, applies, regardless of the reason for the admission, and applies to all Inpatient admissions to a Hospital or Psychiatric Facility in 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 Group 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 Us 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 Group Policy, applies, regardless of the reason for the visit, is in addition to any applicable advanced imaging Cost-Share, and applies to emergency room Facility Services within or outside the Service Area. The Copayment for emergency room Facility Services, if applicable to Your Group Policy, must be satisfied by You for each visit, unless specifically stated otherwise on Your Schedule of Benefits. 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 Group Policy, 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, You may be responsible for paying a percentage of the Allowed Amount for Covered Services. The percentage that You are responsible for is called the Coinsurance Percentage. The Coinsurance Percentage for this Group Policy is listed in the Schedule of Benefits.

When charges are incurred for Covered Services or supplies provided by Participating Providers, this Group 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. If You are Covered under a POS plan and decide to utilize or seek care from Non-Participating Providers, You may incur additional financial fees associated with charges in excess of the Allowed Amount.

D. THE 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 Group Policy pays Covered Services at one hundred percent (100%) of the Allowance determination for all Covered Services and Covered Prescription Drugs (if applicable) for the remainder of that Calendar Year. All Cost-Sharing for Covered Services, including the Calendar Year Deductible, Copayment, and Coinsurance amounts, contribute toward the Out-of-Pocket Maximum Expense Limit. Cost-Sharing for Covered Prescription Drugs incurred under the Group Policy Prescription Drug Rider, if applicable, will also contribute toward the Out-of-Pocket Maximum Expense Limit. Once the Out-of-Pocket Maximum Expense Limit is satisfied, this Group Policy pays one hundred percent (100%) of the Allowance determination for Covered Services and Covered Prescription Drugs for the remainder of that Calendar Year. Unless Your Prescription Drug Coverage includes a separate Out-of-Pocket Maximum Expense Limit, the Out-of-Pocket Expense Limit set forth on Your Schedule of Benefits will apply to both Covered medical Services and Covered Prescription Drugs (if applicable).

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 Group 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 Group 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 OUT-OF-POCKET CALENDAR YEAR MAXIMUM EXPENSE LIMIT

Once You have reached the individual Out-of-Pocket Calendar Year 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 OUT-OF-POCKET CALENDAR YEAR 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 Out-of-Pocket Calendar Year Maximum 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 meets 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 Out-of-Pocket Calendar Year Maximum is the amount applied toward the individual Out-of-Pocket Calendar Year Maximum.

Note: For POS plans, the In-Network out-of-pocket expenses do not accumulate towards the Out-of-Network Out-of-Pocket Maximum Expense Limit shown in the Schedule of Benefits. Out-of-Network out-of-pocket expenses do not accumulate toward the In-Network Out-of-Pocket Maximum Expense Limit shown in the Schedule of Benefits.

We have the right to request for You to verify that You have reached Your Out-of-Pocket Calendar Year Maximum Expense Limit. You may call Our Customer Service Department for information on Out-of-Pocket Maximum Expense Limits.

E. ADDITIONAL EXPENSES YOU MUST PAY

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

- Expenses incurred for non-Covered Services;
- The Premium applicable to Your Certificate;
- Charges in excess of any maximum benefit limitation listed in Your Schedule of Benefits (e.g., the Calendar Year maximums);
- For individuals Covered under a POS plan, charges in excess of the Allowed Amount for Covered Services rendered by Providers who have not agreed to accept Our Allowed Amount as payment in full;
- Any benefit reductions;
- 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; 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 Covered Services to be received from Participating Providers through a contractual arrangement. If a Covered Person receives Covered Services from a Participating Provider (as published in the Provider 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, or 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 lesser of:

- The Provider's charges;
- The usual and customary Provider charges for similar Services in the community where the Services were provided; or
- The charge mutually agreed to by the Health Plan and the Provider within sixty (60) days of the submittal of the Claim.

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

In the event a POS Covered Person receives non-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, the Covered Person will be reimbursed for the cost of the Service at the Health Plan's Allowable Fee Schedule, less applicable Cost-Share amounts. The POS Covered Person will also be responsible for any balance between the Provider's charges and the Health Plan's Allowable Fee Schedule. This balance may be substantial. 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.

The following provisions apply in the event the Covered Person needs to file a Claim for Non-Participating Provider Services.

B. FOUR TYPES OF CLAIMS

As described below, there are four (4) categories of Claims that can be made under the Group 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 Group Policy that require approval in advance are specifically noted in this Group Policy 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 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 Group 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 pre-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, 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 a 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 myHFHP.org and through the Member Portal. A Reimbursement form will be acknowledged on the date that the Health Plan receives the completed form.

Claims for medical Services must be sent to:

Health First Health Plans
ATTN: Benefits Reimbursement Unit
6450 U.S. HWY
Rockledge, FL 32955

Reimbursement requests for Prescription Drugs must be sent to:

Health First Health Plans
ATTN: Pharmaceutical Services Department
6450 U.S. HWY 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 Covered Person believes the Pharmacy has applied the wrong Cost-Sharing amounts, the Covered Person may pay the amount determined by the Pharmacy and submit a Claim for reimbursement to the Health Plan, following the procedures for Post-Service Claims. Reimbursement requests when a discount card or coupon card (other than 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 hereunder. However, if such payments are made, the Covered Person shall submit a timely Claim for reimbursement to the Health Plan. 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 or Pharmaceutical Services Department 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

In light of the expedited time frames for decision of Urgent Care Claims, an Urgent Care Claim for benefits may be submitted to the Health Plans' Medical Management Department by faxing the request to 1.855.328.0059 (toll-free). Verbal requests may be made by calling the Health Plans'

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 state and federal regulations and regulatory guidelines. If a Claim or a portion of a Claim is contested by the Health Plan, the Covered Person or the 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 the 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 according to the following time frames: no later than one hundred and twenty (120) days after receiving an electronic Claim and no later than 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 Florida 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 plan 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 plan 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 Group Policy, 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 Group 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/POS plan, including coverage under labor-management, trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans;
- Any service plan contracts, group practice, individual practice, or other prepayment coverage on a group basis;
- An insurance agreement, including an automobile insurance agreement; 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, contract, 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 total benefits under all Your plans will not exceed one hundred percent (100%) of the total reasonable expenses actually incurred for Covered Services. In the event that the primary payer's payment exceeds Our Allowed Amount, no payment will be made for such Services.

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 payment:

- The benefits of the plan that covers the Insured other than as a Covered Dependent are determined before the benefits of the plan(s) that covers the Insured as a Covered Dependent.
- In the case of a person for whom a Claim is made as a dependent child (except for cases where the Covered Dependent's parents are separated or divorced), the parents' birth dates will be used to determine the order of benefit payments. 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.)

- In the case of a person for whom a Claim is made as a dependent child whose 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 that cover the child as a dependent of the parent with custody of the child will be determined before the benefits of the plan which cover the child as a dependent of the parent without custody.
  - When the parents are divorced and the parent with custody of the child has remarried, the benefits of a program which cover that child as a dependent of the parent with custody shall be determined before the benefits of a plan which cover that child as a dependent of the step-parent. The benefits of a plan which cover that child as a dependent of a step-parent will be determined before the benefits of a plan which covers the child as a dependent 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 a plan which cover the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other program which cover the child as a dependent 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 provisions of 4a. above shall not apply.

When this coordination process reduces the total amount of benefits otherwise payable to a Covered Person under this Group 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 Group Policy.

MEDICARE ELIGIBLES

This section explains how the benefits under this Group Policy coordinate with benefits available under Medicare when You become Covered under Medicare and continue to be eligible and Covered under the Group Policy. Medicare, when used in this Group Policy, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes HMO or comparable coverage that is an approved alternative to Parts A and B of Medicare.

If You are eligible for Medicare due to age (sixty-five (65) years of age or older), then:

- This Group Policy will be the primary plan if Your Coverage under this Group Policy is based on You or Your Spouse's current employment; or
- Medicare will be primary if You elect Medicare coverage or if You are retired.

If You are eligible and elect Medicare due to End-Stage Renal Disease ("ESRD"), then:

- The Group Policy will be the primary plan for the first thirty (30) months; and

- Medicare will be the primary payer after the first thirty (30) months.

If You are eligible for Medicare due to a disability other than ESRD and Your Large Employer has more than one hundred (100) employees, the Group Policy will be the primary plan.

In order to properly administer this provision, the Large Employer shall provide the Health Plan the names of employees, age sixty-five (65) or older who:

- Are Covered under this Group Policy;
- Are employed (not retired);
- Have not elected Medicare coverage; and
- Are not eligible for Medicare due to the ESRD coordination period.

The Large Employer shall provide the Health Plan the names of Spouses, age sixty-five (65) or older, of current employees of any age who:

- Are Covered under this Group Policy;
- Have not elected Medicare coverage; and
- Are not eligible for Medicare due to the ESRD coordination period.

This Medicare Secondary Payer section shall be subject to modification if necessary to conform to or comply with Federal Statutory and Regulatory Medicare Secondary Payer provisions, as those provisions relate to Medicare beneficiaries who are Covered under this Group Policy.

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 Statute.

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 Employee's or Covered Dependent's own insurer (for example, 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 or his/her legal representative 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 Group Policy on behalf of the Covered Person; and/or
- Recover from the Covered Person or his/her legal representative any benefits paid under the Group Policy 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 or her Spouse, dependents, beneficiaries or estate, whether held in trust or constructive trust for the benefit of You/the Insured, his or 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 (whether paid directly or indirectly to You/the Insured, his or her Spouse, dependents, beneficiaries, or estate, whether held in trust or constructive trust for the benefit of You/the Insured, his or her Spouse, dependents, beneficiaries or estate) receives 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 Group Policy 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 agree to hold in a separate trust, for the benefit of the Health Plan, an amount equal to Health Plan's first lien on the total recovery. In addition, the Covered Person and his/her legal representative agree 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 Group 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 under the Group Policy for any illness, Sickness, or bodily Injury, up to the amount of the payment that the Covered Person or his/her legal representative 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 Group Policy.

For clarification, this provision for third-party liability, subrogation, and right of recovery applies to the Covered Person, which is defined under the Health Plan to include Eligible 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 Group Policy. By accepting Coverage under this Group Policy, the Covered Person gives permission for the Health Plan to obtain from or release to any insurance company, 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

Group Policy agrees to provide 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 Group 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 Group Policy shall not duplicate any benefits that are received by or paid to the Covered Person under governmental programs, such as Medicare, Veterans Administration, TRI-CARE (CHAMPUS), or any Workers' Compensation Act, to the extent allowed by law. In any event, if this Group 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 Group 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 Employee 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:

Health First Health Plans
Attn: Appeal Coordinator
6450 U.S. HWY 1
Rockledge, FL 32955

Fax: 1.855.328.0053
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 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 Group Policy within sixty (60) days after written proof of loss has been given as required by this Group 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. Please see the **Right to Legal Action** section of this Certificate.

N. UNUSUAL CIRCUMSTANCES

If the rendering of Services or benefits payable under this Group Policy is delayed or impractical due to: (a) complete or partial destruction of Network facilities; (b) war; (c) riot; (d) civil insurrection; (e) major disaster; (f) disability of a significant part of participating Hospitals and practitioner Network; (g) epidemic; (h) a 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 Providers, 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 Group 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.

O. 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.

VIII. COMPLAINT, GRIEVANCE, AND APPEAL PROCEDURES

A Complaint is an informal expression of dissatisfaction related to benefits or Services provided under this Certificate. A Grievance is a formal Complaint regarding Service issues or the quality of care provided. 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 medical urgency into account.

A. 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. You or Your authorized representative should contact Customer Service at 1.855.443.4735 with any initial Complaint, and the Customer Service Representative will make every effort to resolve the problem within three (3) working days. A formal Grievance may also be filed according to the procedure defined below, with assistance provided if necessary.

B. 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, You or Your 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 must be sent to:

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

Fax: 1.855.328.0053
Email: HFHPinfo@HF.org

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 a Grievance Coordinator toll-free at 1.855.443.4735, Monday – Friday from 8 a.m. to 6 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.

C. APPEAL PROCEDURES – GENERAL INFORMATION

If benefits are denied, in whole or in part, the Health Plan will provide You or Your 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 Your health or ability to regain maximum functioning. The Health Plan reserves the right to determine if Your 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 an Appeal Coordinator at 1.855.443.4735 (toll-free) Monday – Friday 8 a.m. to 6 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.

You or Your authorized representative shall have the right to access, upon request and without charge, copies of all documents, records, and other information relevant to Your Appeal.

D. 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, You or Your 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 must be sent to:

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

Fax: 1.855.328.0053
Email: HFHPinfo@HF.org

Expedited Appeals may be filed verbally by contacting an Appeal Coordinator at 1.855.443.4735 (toll-free) Monday – Friday 8 a.m. to 6 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 Your medical Condition requires, but in no longer than seventy-two (72) hours. Verbal notice of the decision will be provided within the seventy-two (72) hour time frame, with a written decision provided within three (3) days after the verbal notification.

Extensions: One (1), fourteen (14) calendar day extension is permitted if additional information is necessary to make a decision on the Appeal, and You or Your 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.

E. APPEAL PROCEDURE – SECOND-LEVEL REVIEW (MEMBER ASSISTANCE PANEL HEARING)

REQUESTING A SECOND-LEVEL APPEAL REVIEW

If a first-level Appeal is not resolved in Your favor, You or Your authorized representative may request a second-level Appeal hearing by the Health Plan's Member Assistance Panel. The request may be made verbally or in writing within one hundred and eighty (180) days of receipt of the first-level decision. Requests must be made through an Appeal Coordinator at the address or phone number listed under the first-level Appeal procedure. The request for second-level review should include any additional information You would like considered, including medical records, letters from Providers, or any other helpful information.

The Member Assistance Panel Hearing will be scheduled at the administrative offices of the Health Plan. The majority of the Member Assistance Panel representatives shall be individuals who previously were not involved in any prior decision on the case and will consist of Health Plan management or clinical professionals qualified to review the issue under Appeal, with external individuals included as appropriate. You or Your authorized representative may attend the Member Assistance Panel in person, by teleconference, or through any other available technology and will have sufficient time to present Your case and provide any additional information You would like considered.

An expedited second-level Appeal process is available if the standard time frame would seriously jeopardize Your health or ability to regain maximum functioning, or would subject You to severe pain that cannot be adequately managed without the requested care in the opinion of Your Physician. We will decide if the expedited process is needed and will make a decision within seventy-two (72) hours if the fast process is granted. If Your Appeal qualifies for the expedited process, You may also request external review. To request an Expedited Appeal or external review, call the Customer Service Department toll-free at 1.855.443.4735.

SECOND-LEVEL REVIEW TIME FRAMES

For standard pre-service Appeals, the Member Assistance Panel Hearing will generally be scheduled within ten (10) calendar days of the request for the second-level review, or when a delay is requested by You or Your authorized representative, within thirty (30) days of the second-level Appeal request.

A decision will be made and written notification will be provided within five (5) calendar days after the hearing.

For standard post-service Appeals, the Member Assistance Panel Hearing will be scheduled within twenty-five (25) calendar days of the request for the second-level review. A decision will be made and written notification will be provided within five (5) calendar days after the hearing.

For Expedited Appeals, the Member Assistance Panel Hearing will be scheduled in a time frame that will allow a decision to be made within seventy-two (72) hours of receipt of the initial Appeal, or when a delay is requested by You or Your authorized representative, within thirty (30) days of the second-level Appeal request. A decision will be made and verbal notification will be provided to the Covered Person or their authorized representative within seventy-two (72) hours of the initial Appeal request, with written notification provided within three (3) calendar days after the verbal notification. If a delay is requested, a written decision will be provided within five (5) calendar days after the hearing.

Extensions: One (1) fourteen (14) calendar day extension is permitted if additional information is necessary to make a decision on the Appeal, and You or Your authorized representative agrees to the extension. If the Appeal cannot be resolved within the required time frame, You will be notified of the need for an extension in writing before the required time frame has elapsed. This written notice will include the reason for the delay, request Your agreement to the extension, and will inform You of the date by which the decision will be made. For Expedited Appeal extensions, You may be notified verbally within the 72-hour time frame, with a written notice provided within three (3) calendar days.

F. 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 a second-level Appeal, You or Your 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 Your 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, You or Your authorized representative must contact the Health Plan by writing to the address or calling the number below:

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

Phone: 1.855.443.4735
Fax: 1.855.328.0053
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 Group 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-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 You or Your authorized representative in writing of the Appeal's acceptance for external review and of Your right to submit additional information within ten (10) calendar days of receiving the request. The final decision will be issued within forty-five (45) days after receiving the request. For Expedited Appeals, the IRO will notify You or Your authorized representative of the decision as quickly as Your 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.

G. ADDITIONAL ASSISTANCE WITH GRIEVANCES & APPEALS

You or Your authorized representative have 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 32399-0322
Toll-free: 1.877.693.5236
Email: Consumer.Services@myfloridacfo.com

H. RIGHT TO LEGAL ACTION

If this Group Policy is subject to ERISA regulations, civil action may be taken under ERISA §502(a) after completing the internal Appeal process. The deadline to file legal action is as follows:

- Six (6) months after completion of the internal Appeal procedure; or
- Sixty (60) months after the earlier of:
  - The date benefits were denied,
  - The date benefits were received at a level less than what You believed was required to be provided under this Group Policy, or
  - The date You knew, or reasonably should have known, the principal facts upon which the Claim was based.

IX. THE HEALTH PLAN'S PHARMACY PROGRAM

The benefits and provisions described within this section are applicable only to a Group Policy that includes a Prescription Drug Rider. When applicable, it is important that You review the information

herein, along with the information set forth in the Prescription Drug Rider attached to this Certificate, to ensure You understand Your Coverage through 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. Please note that before payment will be made for Covered Prescription Drugs and supplies, the Calendar Year Deductible, if applicable, must be satisfied. The Prescription Drug Rider attached to this Certificate will indicate whether or not Prescription Drugs and supplies are subject to a Calendar Year Deductible, and if so, whether or not the Calendar Year Deductible is integrated with Your medical Coverage.

Once the Calendar Year Deductible, if applicable, has been satisfied, You must pay, at the time of purchase, the appropriate Copayment or Coinsurance percentage of the Participating Pharmacy Allowance or Non-Participating Pharmacy Allowance, as applicable, indicated on the Prescription Drug Rider for each Prescription.

Covered Prescription Drugs are categorized into tiers and listed in Your Group Policy Formulary. In the Formulary, You will find Preferred Generic Prescription Drugs, Non-Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Brand Name Prescription Drugs, and Specialty Drugs that are Covered under Your Group Policy. You must pay the applicable Cost-Share, as indicated on Your Prescription Drug Rider, based on the tier assigned in the Formulary. Your Group Policy may not Cover all tiers listed on the Formulary. Please see the Prescription Drug Rider attached to this Certificate.

The Formulary is subject to change without advance notice. Updated Formularies are posted to the Health Plan's website at myHFHP.org and the Member portal as changes are made. You may also contact the Customer Service Department for assistance.

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

- Using equivalent generic alternatives when they are available for brand name Drugs;
- Using Participating Pharmacies; and
- Choosing Preferred Prescription Drugs rather than Non-Preferred Prescription Drugs.

The Health Plan will not accept requests to move a medication to a different tier based on out-of-pocket expenses.

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

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. This is true even for Covered Persons enrolled in a POS plan.

Covered Prescription Drugs and supplies are products, Drugs, medicine, or medication that, under federal or state law, may be dispensed only by Prescription from a participating Physician or medical Provider authorized to write Prescriptions. 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's Pharmaceutical Services Department.

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 are Covered. Due to the Preventive Care provision of the Affordable Care Act ("ACA"), some of these contraceptives will be at no Cost-Share. 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 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 professional 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:

- 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 certain Preventive medications that are noted on the Formulary as No Cost-Share ("NCS") designee.

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 Drug or supply filled at an Out-of-Network Pharmacy is excluded from Coverage. This exclusion also applies to Covered Persons enrolled in a POS plan;
- 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. This exclusion does not apply to Covered Persons with POS benefits;
- 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 (notated in Tier NCS in the Formulary). A Physician or other health care professional acting within the scope of his or her license 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" or 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;
- Any injection medication that is not self-administered (i.e., IV administration, Medical Professional administration only, etc.) unless approved by the 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 Health Plan's Pharmacy and Therapeutics ("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 date of termination 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 AC A (notated as Tier NCS in the Formulary);
- 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 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) days supply of any one (1) Prescription Drug are excluded from Coverage;
- For HMO Covered Persons: 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;
- For HMO Covered Persons: Any Drug or supply filled at an Out-of-Network Pharmacy is 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 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 not approved by the FDA under the Federal Food, Drug, and Cosmetic Law and Regulations are excluded from Coverage;
- 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; and
- Food or medical food products, whether prescribed or not, are excluded from Coverage.

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 Group 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 Group Policy.

When a request for exception is approved by the Health Plan, Your Cost-Share will vary depending on the cost of the Drug. Prescription Drugs and supplies with a total cost of more than one thousand dollars ($1,000) will be approved at the Tier 5 Cost-Share. Prescription Drugs and supplies with a total cost of one thousand dollars ($1,000) or less will be approved at the Tier 4 Cost-Share.

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

Toll Free: 1.855.443.4735
TTY/TDD relay: 1.800.955.8771

Your prescribing Physician can also submit an exception request form to Our Pharmacy Department by fax at 1.855.328.0061. This form is available on Our website at myHFHP.org.

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 fourteen (14) days following receipt of the request. If the Health Plan grants an exception request (limitations may apply such as quantity limits, frequency, dosage form) Coverage for a non-Formulary Drug will be approved for the requested time frame from the prescriber, until the end of the benefit year, up to the maximum Allowable recommended use by the FDA, or up to no more than one (1) year from the time of the approval, whichever is less or is determined to be appropriate by the Health Plan.

Expedited Exception Request

The Health Plan will make its Coverage determination on an expedited review request based on urgent circumstances and will notify the Covered Person or the Covered Peron'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 an exception request, (limitations may apply such as quantity limits, frequency, dosage form) Coverage for a non-Formulary Drug will be approved for the requested time frame from the prescriber, until the end of the benefit year, up to the maximum Allowable recommended use by the FDA, or up to no more than one (1) year from the time of the approval, whichever is lesser or is determined to be appropriate by the Health Plan.

External Exception Request Review

If the Health Plan denies a request for a standard exception or for an expedited exception, the Covered Person or 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 a standard, and no later than twenty-four (24) hours following its receipt of the request, if the original request was an expedited exception request.

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 Deductible, if applicable, 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; and
- Whether the Prescription Drug is purchased from the Mail Order Pharmacy.

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

Non-Formulary Prescription Drugs that are approved through the Prior Authorization process may be subject to the highest tier Cost-Share in the Formulary. If the Prescription Drug Rider attached to this Certificate does not provide Coverage for the highest Cost-Sharing tier, the medication is subject to the full contracted price, and this amount will not accumulate to the Out-of-Pocket Maximum Expense Limit.

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 Prescription Drug Rider attached to this Certificate. 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 or with Our Pharmacy Benefit Management ("PBM"); 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 myHFHP.org.

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 or Our PBM.

MAIL ORDER PHARMACY

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 myHFHP.org for specifics.

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 documentation from You and Your Physician that the designated Drugs in the Formulary are not appropriate for You because of a documented allergy, ineffectiveness, or side effects.

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 Coverage 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 Coverage Authorization, refer to the Formulary. Information on Our Pharmacy utilization review programs is published in the Formulary at myHFHP.org. 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 and attached Prescription Drug Rider. Ultimately, the final decision concerning whether a Prescription Drug should be prescribed must be made by You and the 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. DEFINITIONS

This section defines many of the terms used in this Group Policy. 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 Group Policy, 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.

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 has 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" is used to refer to the final, amended version of the law.

ALLOWABLE OR ALLOWABLE FEE SCHEDULE means the dollar amount the Health Plan allows towards the cost for Out-of-Network Covered Services for POS Covered Persons POS Covered Persons are responsible for any dollar amount a Non-Participating Provider charges in excess of the Allowable Fee Schedule, which is currently based on one hundred and fifty percent (150%) of the Medicare Fee Schedule. The Allowable Fee Schedule is subject to change without prior notice to affected Covered Persons.

ALLOWANCE 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 market(s), 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, if You are enrolled in POS Coverage, 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. Individuals Covered under a POS plan may be responsible for these additional charges.

AMBULANCE means a ground or water vehicle, airplane, or helicopter properly licensed pursuant to Chapter 401 of 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 Group 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.

AUTISM SPECTRUM DISORDER means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric

Association: Autistic disorder, Asperger's syndrome, or Pervasive developmental disorder not otherwise specified.

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

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 Chapter 383 of 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 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).

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

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 Drug manufacturer for distribution or sale, whether or not the other company markets the Drug under a generic or other nonproprietary name.

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.

CERTIFICATE OF COVERAGE or CERTIFICATE means the document outlining Your specific plan and benefits and Coverage provisions, including exclusions and limitations. The Certificate is part of the Group Policy.

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 advanced nurse practitioner 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 Florida Statute, 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 means the sharing of Covered health care expenses between the Health Plan and a Covered Person, as specifically set forth in the Schedule of Benefits and any Rider or Endorsement, if applicable. Coinsurance is expressed as a percentage rather than as a flat dollar amount. After the Calendar Year Deductible requirement is met, if applicable, the Health Plan will pay a percentage of the Allowed Amount for Covered Services, as listed in Your Schedule of Benefits and any Rider or Endorsement attached to this Certificate.

COMPLAINT means any 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 approves 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, bodily dysfunction, or complications of pregnancy 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 a specific dollar amount that the Covered Person must pay upon receipt of Covered Services or for a Group Policy with an attached Prescription Drug Rider, 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 Rider or Endorsement attached to this Certificate.

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. Examples of Cosmetic Surgery include 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 Rider or Endorsement 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 Group Policy other than as the Insured. See the **Eligibility Under This Group Policy** subsection of the **Administrative Provisions** section of this Certificate for more information.

COVERED EMPLOYEE means an Eligible Employee who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually Covered, under the Group Policy.

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

COVERED PRESCRIPTION DRUG means, for a Group Policy with an attached Prescription Drug Rider, 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 mean those Medically Necessary Services and supplies described in the **Covered Services** section of this Certificate and any Rider or Endorsement attached to it.

CREDITABLE COVERAGE means health insurance coverage under 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;
- Indian Health Service;
- The Peace Corps;
- Public health plan (any plan established or maintained by a state, the U.S. government, and a foreign country);
- Children's Health Insurance Program ("CHIP"); or
- A state health insurance high-risk pool.

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. Examples of 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 (when applicable) which the Covered Person must actually pay each Calendar Year to appropriately licensed Health Care Providers before the Health Plan's payment for Covered Services subject to the Deductible begins.

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 the 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.

DOWN SYNDROME means a chromosomal disorder caused by an error in cell division which results in the presence of an extra whole or partial copy of chromosome 21.

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 PROVIDER means a person or entity that is properly licensed, if applicable, under Florida law (or a 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, with respect to the Large Employer and to the Covered Person properly enrolled when Coverage first becomes effective, 12:00 a.m., Eastern Time, on the date so specified on the Group Policy Information Page. With respect to the Covered Persons who are subsequently enrolled, it means 12:00 a.m., Eastern Time, on the date on which Coverage will commence as specified in the **Effective Dates** section of this Certificate.

ELIGIBLE DEPENDENT means:

- An Insured's legal Spouse;
- An Insured or their legal Spouse's Natural born, Adopted, Foster, or step child(ren) up through the limiting age described in the **Eligibility Under This Group Policy** section of this Certificate;
- A child for whom the Insured or their legal Spouse has been court-appointed as legal guardian or legal custodian up through the limiting age described in the **Eligibility Under This Group Policy** section of this Certificate; and

- A Newborn child of a Covered Dependent child if properly enrolled. Coverage for such Newborn child will automatically terminate eighteen (18) months after the birth of the Newborn child.

ELIGIBLE EMPLOYEE means an individual who meets and continues to meet all of the eligibility requirements described in the **Eligibility Under This Group Policy** section of this Certificate and is eligible to enroll as an Insured. An individual who is an Eligible Employee is not an Insured until such individual has actually enrolled with the Health Plan and been accepted for Coverage.

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 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 in this Group Policy for Coverage.

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 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 the Covered Person or other patients with the same or similar Condition;
- Reports, articles, or written assessments in authoritative, 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 includes 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 to Covered Persons with a Group Policy that includes a Prescription Drug Rider 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 myHFHP.org for the most current Formulary, or You may call Our Customer Service Department.

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 a 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 him or her.

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 Group Policy continues in effect. However, if Premium is not paid during the Grace Period, Coverage will terminate as of the last date of the month for which Premium was paid.

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 Group Policy.

GROUP POLICY means the written document, which is the agreement between the Large Employer and the Health Plan, whereby Coverage and benefits specified herein will be provided to Covered Persons. The Group Policy includes the Certificate of Coverage, all applications, enrollment forms, rate letters, face sheets, Riders, amendments, addenda exhibits, and Schedule of Benefits that are, or may be, incorporated in this Group 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. Habilitative Services are not Covered under this Group Policy, except as set forth in the Autism Services and Treatment category of the **Covered Services** section of this Certificate.

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, nurse practitioners, 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 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 Group Policy.

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 Internal Revenue Service ("IRS").

HOME HEALTH AGENCY means a properly licensed agency or organization which 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 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, 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 Group Policy. It only expands the setting where Covered Services may be performed for Coverage purposes.

HOSPITAL SERVICE(S) (as expressly limited or excluded by this Group Policy) 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.

INITIAL ENROLLMENT PERIOD or INITIAL ENROLLMENT means the period of time during which an employee or dependent is first eligible to enroll. It begins on an employee's or a dependent's initial date of eligibility and ends thirty-one (31) days later.

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 Group Policy.

IN-NETWORK PROVIDER means any Health Care Provider who, at the time Covered Services were rendered to You, was under contract with the Health Plans 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 Directory). For payment purposes under this Group 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 the Eligible Employee included for Coverage under this Group Policy. Eligibility requirements for employees are specified in the **Eligibility Under this Group Policy** section of this Certificate.

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.

LARGE EMPLOYER means the employer who has signed a contract with the Health Plan allowing this group health insurance Coverage to be provided. To be eligible for Coverage, a Large Employer means in connection with a Health Benefit Plan with respect to a Calendar Year and a plan year, any firm, corporation, partnership, or association that is actively engaged in business and is not defined as a Small Employer under Section 627 of the Florida Statutes or as a sole proprietor.

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.

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 the Large Employer, an Applicant, or Covered Person which would have affected Our decision to issue this Group Policy, issuance of different benefits, or issuance of this Group Policy 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. A Condition is Medically Necessary if, in Our determination, it is:

- Consistent with the symptom, 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 Group Policy 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 Group Policy as determined by Us. In applying the definition of Medical Necessity in this Group Policy, 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.

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.

MEMBER means the Insured and any Covered Dependents Covered under this Group Policy.

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 International Classification of Diseases, Ninth Edition, Clinical Modification ("ICD-9 CM"); the International Classification of Diseases, Tenth Revision, Clinical Modification ("ICD-10-CM"); or their equivalents in 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) who has not made an agreement with

the Health Plan to provide Services to Covered Persons and is not published in the Provider 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 Licensed 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 an annual period defined by the Large Employer, for at least thirty (30) days, during which: 1) If the Large Employer offers more than one (1) health plan option, an employee may change to one (1) of the alternatives offered; and 2) Employees who decided not to enroll for Coverage with the Health Plan during the Initial Enrollment Period may now enroll themselves and their Eligible Dependents.

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-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 PROVIDER(S) means a Provider who, at the time Health Care Services were rendered, did not have a contract with Us to participate in the Health Plan's 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 Group 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 the similar law or 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 59A of the F.A.C or similar laws of another state.

OUTPATIENT SURGERY includes any procedure performed in an Ambulatory Surgery Center or Hospital Facility, including diagnostic tests or any other minor procedures.

OVER-THE-COUNTER ("OTC") means supplies that can be obtained without a Prescription. .

PAIN MANAGEMENT includes 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.

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 having the Condition is under the regular care of a Physician. Determination of Partial Disability shall be made by the Physician on the basis of a medical examination of the Insured 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 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 PHARMACY means, for pharmacies located in the Service Area, a Pharmacy that has signed a Participating Pharmacy Provider Agreement with Us or the PBM 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 which is available to Covered Persons under this Group Policy. This includes a participating Hospital, a participating Physician, or other participating Health Care Provider that 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 Directory.

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.

PHARMACY BENEFIT MANAGER ("PBM") are companies that manage Prescription Drug benefits on behalf of the Large Employer.

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 a similar applicable law 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 Group Policy 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.

POINT-OF-SERVICE ("POS") means a benefit plan under which a Covered Person has the right to access certain Medically Necessary Covered Services from Non-Participating Providers without a referral from the HMO PCP or the Health Plan. Certain Services require Authorization from the Health Plan to determine Medical Necessity.

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 the Plan that is not a Pre-Service Claim, an Urgent Care Claim, or a Concurrent Care Claim.

PREFERRED PRESCRIPTION DRUG means a Prescription Drug on one (1) of the preferred Formulary tiers then in effect. The preferred tiers are contained within the Formulary.

PREMIUM means the amount established by the Health Plan to be paid to the Health Plan by the Large Employer or on behalf of the Large Employer in consideration of the benefits provided under this Group 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 the Group Policy 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") means a Family Practitioner, Internist, Pediatrician, or their Physician Extender (i.e., Physician Assistant or Nurse Practitioner) licensed to provide, prescribe, and authorize care and treatment for the Covered Person. A current listing of contracted PCPs is published in the Health Plan's Provider Directory.

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 Group Policy.

PROVIDER DIRECTORY means a listing of all contracted Participating Providers, including addresses and telephone numbers, for the plan of which You are a Covered Person. Copies of this Directory are available on Our website, myHFHP.org, 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 Group Policy, a Psychiatric Facility is not a Hospital or a Substance Abuse 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 BENEFICIARY means an individual who is entitled to COBRA continuation of Coverage because he or she was Covered by a group health plan on the day before a "Qualifying Event."

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.

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.

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.

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 Group Policy, the initial breast reconstruction following a 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, which defect is determined by a Physician to have been present at the time of birth.

RESIDENTIAL TREATMENT FACILITY means a community-based residence for individuals exhibiting symptoms of mental illness who are in need of a structured living environment.

RIDER means any attached written description of additional Covered Health Care Services not described in this Certificate. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by Us and are subject to all conditions, limitations, and exclusions of the Certificate except for those that are specifically amended in the Rider.

SCHEDULE OF BENEFITS means the document that summarizes Your Coverage under the Health Benefit Plan and states the Cost-Sharing amounts the Covered Person 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 Service Area for this Group Policy is all of Brevard County.

SICKNESS means bodily disease for which expenses are incurred while Coverage under this Health plan benefit is in force.

SKILLED NURSING CARE means Skilled Nursing Services, above the level of Custodial Care, which is 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 by, or supervised by, a Registered Nurse;
- It must not primarily be a place of rest, a nursing home, or place of care for senility, Drug addiction, alcoholism, intellectual disability, psychiatric disorders, chronic brain syndromes, or a place for the aged;
- It must be licensed as a SNF by the State of Florida or similar applicable laws of another state; and
- It must be accredited as a SNF by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a SNF by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by the Health Plan.

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") or SPECIAL ENROLLMENT means a time outside of the OEP during which You and Your family have a right to sign up for health Coverage. You may qualify for an SEP following certain qualifying life events that involve a change in family status (i.e. marriage or birth of a child) or loss of other health coverage.

SPECIALIST(S) means a Physician or their Physician Extender (i.e., Physician Assistant or Nurse Practitioner) 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 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.

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 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, or rendered in a Physician's office for Urgent Care after-hours, and the Covered Services for those 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 Service Area.

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 the Covered Person 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.

WAITING PERIOD means the period, with respect to this Group Policy and an individual who is a potential participant or beneficiary under the Group Policy, that must pass with respect to an individual before the individual is eligible to be Covered for benefits under the terms of this Group Policy.

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 Group Policy.

XI. NOTICES

A. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Health Plan provides Coverage under this Group Policy for Mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a Mastectomy

(including lymphedema). If a Covered Person is receiving Services in connection with a Mastectomy, Coverage is also provided for the following, as the Covered Person and the attending Physician determine to be appropriate:

- All stages of reconstruction of the breast on which the Mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the Mastectomy, including lymphedema.

The amount the Covered Person must pay for Covered Services is the same as are required for any other Covered Service. Limitations on Coverage are the same as for any other Covered Service.

B. STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, the Large Employer 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 Plan Sponsor 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 Large Employer 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 Large Employer 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 following a vaginal delivery or ninety-six (96) hours following a delivery by cesarean section.

C. STATEMENT OF EMPLOYEE RETIREMENT SECURITY ACT OF 1974

If You participate in the Health Plan through an employer that is not a religious organization or political subdivision, You are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Certificate. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each Insured with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care Coverage for Yourself, Spouse, or dependents if there is a loss of Coverage under the Group Policy as a result of a Qualifying Event. You or Your dependents may have to pay for such Coverage. Review this Certificate and the documents governing the plan on the rules governing Your COBRA continuation Coverage rights.

- You should be provided a Certificate, free of charge, from Your group health plan or Health Insurance Issuer when You lose Coverage under the plan, when You become entitled to elect COBRA continuation Coverage, and when Your COBRA continuation Coverage ceases, if You request it before losing Coverage, or if You request it up to twenty-four (24) months after losing Coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of You and other plan participants and beneficiaries. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a (pension, welfare) benefit or exercising Your rights under ERISA.

Enforce Your Rights
If Your Claim for a benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, You may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay You up to one hundred and ten dollars ($110) a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If You have a Claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court. In addition, if You disagree with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees (for example, if it finds Your Claim is frivolous).

Assistance with Your Questions
If You have any questions about Your plan, You should contact the plan administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the plan administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

D. 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: myHFHP.org.

E. MICHELLE'S LAW

Michelle's Law, a federal law enacted on October 9, 2008, became effective January 1, 2010. This law provides for continuation of dependent eligibility because of a reduction in full-time class status or a medical leave of absence from school. The leave of absence or reduction in hours must be Medically Necessary and must commence while the eligible student is suffering from a serious illness or Injury that would otherwise terminate Coverage under the plan. Other requirements exist in order for these provisions to apply (i.e., the student must have been enrolled in the group health plan before the first day of the leave). There must also be supporting written certification by a participating Physician indicating that the student meets the criteria for the change in enrollment status. The Coverage must be extended for at least one (1) year; however, Coverage may end earlier for certain reasons, such as the student aging out of the plan under the Group Policy's dependent eligibility definitions.

XII. COVERED PERSON'S 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, economic status, mental or physical disability, health status, Claims experience, genetic information, geographic location within this Service Area, or need for health Services;

- 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 health care 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;
    - 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 Our Plan;
- 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 upon 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).

XIII. 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 preventative 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.

[1]*Health First Privia Medical Group, LLC is a Limited Liability Company attached to the Health First, 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."