

device utilized by practicing physicians in treating other patients with the same or a similar condition; or

- 12.14.04 Such medication, treatment, procedure or device is the subject of an ongoing Phase I or Phase II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosages, toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question.
- 12.15 **Eye care** including:
 - 12.15.01 Eye examinations for Members 18 years of age or older for the purpose of determining the need for sight correction (such as eye glasses or contact lenses);
 - 12.15.02 Training or orthoptics, including eye exercises; or
 - 12.15.03 Radial keratotomy, refractory keratoplasty, Lasik surgery or any other corneal surgical procedure to correct refractive error.
- 12.16 **Foot supports** are not covered. These include orthopedic or specialty shoes, shoe build-ups, shoe orthotics, shoe braces, and shoe supports. Also excluded is routine foot care, including trimming of corns, calluses, and nails.
- 12.17 **Gastric stapling**, gastric bypass, gastric banding, gastric bubbles, and other procedures for the treatment of obesity or morbid obesity, as well as any related evaluations or diagnostic tests. Ongoing visits other than establishing a program of obesity control.
- 12.18 **Gender reassignment** surgery as well as any service, supply, or medical care associated with gender reassignment or gender identity disorders.
- 12.19 **Home monitoring devices** and measuring devices (other than apnea monitors), and any other equipment or devices for use outside the Hospital.
- 12.20 **Hospital Services** that are associated with excluded surgery or Dental Care.
- 12.21 **Hearing examinations** for Members 18 years of age or older for the purpose of determining the need for hearing correction.
- 12.22 **Infertility diagnosis, treatment, and supplies**, including infertility testing, treatment of infertility, diagnostic procedures and artificial insemination, to determine or correct the cause or reason for infertility or inability to achieve conception. This includes artificial insemination, in-vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures. Also excluded are obstetrical benefits when such pregnancy is the subject of a preplanned adoption arrangement, or surrogacy, as defined under Chapter 63, *Florida Statutes*. Medications for the treatment of infertility are not covered.
- 12.23 **Immunizations and medications** for the purpose of foreign travel or employment.
- 12.24 **Mandibular and maxillary osteotomies** except when Medically Necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.
- 12.25 **Medical care or surgery** not authorized by a Participating Provider, except for Emergency Medical Services and Care, or not within the benefits covered by AvMed.
- 12.26 **Medical supplies** including, but not limited to: pre-fabricated splints, Thromboembolic/Support hose and all other bandages, except as provided in Sections 10.22 and 10.37.
- 12.27 **Non-participating Providers**. Any treatment or service from a Non-participating Provider, except in the case of an emergency or when specifically pre-authorized by AvMed (see Sections 3.16 and 3.17),

including hospital care from a non-participating Attending Physician or a non-participating Hospital, if elected by a member. In such circumstances, coverage is excluded for the entire episode of care, except when the admission was due to an emergency or with the prior written authorization of AvMed.

- 12.28 **Organ donor treatment and services.** the Medical Services and Hospital Services for a donor or prospective donor who is an AvMed Member when the recipient of an organ transplant is not an AvMed Member. Coverage is provided for costs associated with the bone marrow donor-patients to the same extent as the insured recipient. The reasonable costs of searching for the bone marrow donor is limited to family members and the National Bone Marrow Donor Program. Post-transplant donor complications will not be covered.
- 12.29 **Over-the-counter medications,** and prescription medications not otherwise covered including all contraceptives (medications and devices), hypodermic needles and syringes and Self-Administered Injectable Medications except insulin and insulin syringes for the treatment of diabetes as outlined in Section 10.06.
- 12.30 **Personal comfort items** not Medically Necessary for proper medical care as Part of the therapeutic plan to treat or arrest the progression of an illness or injury. This Exclusion includes, but is not limited to: wigs (including partial hair pieces, weaves, and toupees), personal care kits, guest meals and accommodations, maid services, televisions/radios, telephone charges, photographs, complimentary meals, birth announcements, take home supplies, travel expenses (other than Medically Necessary ambulance services that are provided for in Section 10.01), air conditioners, humidifiers, dehumidifiers, and air purifiers or filters.
- 12.31 **Physical examinations or tests,** such as premarital blood tests or tests for continuing employment, education, licensing, or insurance or that are otherwise required by a third party.
- 12.32 **Private duty nursing services.**
- 12.33 **Rehabilitation programs.** Alcohol or substance abuse rehabilitation, vocational rehabilitation, pulmonary rehabilitation, long term rehabilitation, or any other rehabilitation program.
- 12.34 **Removal of benign skin lesions** and warts, moles, skin tags, lipomas, keloids, and scars, is not covered, even with a recommendation or prescription by a physician.
- 12.35 **Reversal of sterilization** procedures.
- 12.36 **Sexual dysfunction.** All medications, devices, and other forms of treatment related to a diagnosis of sexual dysfunction, regardless of etiology.
- 12.37 **Smoking cessation.** Any service or supply to eliminate or reduce dependency on or addiction to tobacco, including but not limited to: nicotine withdrawal programs, facilities, and supplies (e.g. transdermal patches, Nicorette gum).
- 12.38 **Speech therapy** for delayed or abnormal speech pathology.
- 12.39 **Substance Abuse Treatment.** Treatment for chronic alcoholism and chronic drug addiction, except those services offered as a basic health service. See Section 11.13.
- 12.40 **Surgically implanted devices and any associated external devices,** except for cardiac pacemakers, intraocular lenses, cochlear implants, artificial joints, orthopedic hardware and vascular grafts. Dental appliances, other corrective lenses and hearing aids, including the professional fee for fitting them, are not covered.
- 12.41 **Temporomandibular Joint Dysfunction (TMJ).** Services related to the diagnosis/treatment of TMJ except when Medically Necessary; all dental treatment for TMJ.

- 12.42 **Termination of pregnancy** unless deemed Medically Necessary by the Medical Director, subject to applicable State and Federal laws or as specified in the Elective Termination of Pregnancy amendment to the Subscribing Group Contract.
- 12.43 **Travel expenses** including expenses for ambulance services to and from a physician or Hospital except in accordance with Section 10.01.
- 12.44 **Treatment for armed forces service-connected medical care** (for both sickness and injury).
- 12.45 **Treatment of a condition** resulting from:
 - 12.45.01 Participation in a riot or rebellion;
 - 12.45.02 Engagement in an illegal occupation;
 - 12.45.03 Your participation in, or commission of, any act punishable by law as a felony whether or not you are charged or convicted.
- 12.46 **Ventilator dependent care**, except as provided in Part X (Schedule of Basic Benefits) for 100 days lifetime maximum benefit.
- 12.47 **Workers' Compensation benefits.** Any sickness or injury for which the covered person is paid benefits, or may be paid benefits if claimed, if the covered person is covered or required to be covered by Workers' Compensation. In addition, if the covered person enters into a settlement giving up rights to recover past or future medical benefits under a Workers' Compensation law, AvMed shall not cover past or future Medical Services that are the subject of or related to that settlement. Furthermore, if the covered person is covered by a Worker's 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, AvMed shall not cover the balance of any costs remaining after the program has paid.

XIII. COORDINATION OF BENEFITS

- 13.01 The services and benefits provided under this Contract are not intended to and do not duplicate any benefit to which Members are entitled under any other Group Health Insurance, HMO, personal injury protection and medical payments under the automobile insurance laws of this or any other jurisdiction, governmental organization, agency, or any other entity providing health or accident benefits to a Member, including but not limited to: Medicare, Worker's Compensation, Public Health Service, Champus, Maritime Health Benefits, or similar state programs as permitted by contract, policy, or law. AvMed coverage will be primary to Medicaid and Children's Health Insurance Program (CHIP) benefits.
- 13.02 If any covered person is eligible for services or benefits under 2 or more plans as set forth in Section 13.01, the coverage under those plans will be coordinated so that up to but not more than 100% of any eligible expense will be paid for or provided by all such plans combined. The Member shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to AvMed. Failure to do so will result in nonpayment of Claims. Requested information should be provided to AvMed within 30 days of request or Member will be responsible for payment of the Claim. Information received after one year from date of service will not be considered.
- 13.03 The standards governing the coordination of benefits are the following, pursuant to the provisions of Chapter 627.4235, *Florida Statutes*:

- 13.03.01 The benefits of a policy or plan that covers the person as an employee, member, or subscriber, other than as a dependent, are determined before those of the policy or plan which covers the person as a dependent.
- 13.03.02 Except as stated in Subsection 13.03.03, when 2 or more policies or plans cover the same child as a dependent of different parents:
- a) The benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls earlier in a year are determined before the benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls later in the year; but
 - b) If both parents have the same birthday, the benefits of the policy or plan which covered the parent for a longer period of time are determined before those of the policy or plan which covered the parent for a shorter period of time.
 - c) However, if a policy or plan subject to the rule based on the birthday of the parents as stated above coordinates with an out-of-state policy or plan which contains provisions under which the benefits of a policy or plan which covers a person as a dependent of a male are determined before those of a policy or plan which covers the person as a dependent of a female and if, as a result, the policies or plans do not agree on the order of benefits, the provisions of the other policy or plan shall determine the order of benefits.
- 13.03.03 If 2 or more policies or plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:
- a) First, the policy or plan of the parent with custody of the child;
 - b) Second, the policy or plan of the spouse of the parent with custody of the child; and
 - c) Third, the policy or plan of the parent not having custody of the child.
 - d) However, if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the child and if the entity obliged to pay or provide the benefits of the policy or plan of that parent has actual knowledge of those terms, the benefits of that policy or plan are determined first. This does not apply with respect to any claim determination period or plan or policy year during which any benefits are actually paid or provided before that entity has that actual knowledge.
- 13.03.04 The benefits of a policy or plan which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a policy or plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other policy or plan is not subject to this rule, and if, as a result, the policies or plans do not agree on the order of benefits, this Subsection shall not apply.
- 13.03.05 If none of the rules in Subsections 13.03.01, 13.03.02, 13.03.03, or 13.03.04 determine the order of benefits, the benefits of the policy or plan which covered an employee, member, or subscriber for a longer period of time are determined before those of the policy or plan which covered that person for the shorter period of time.
- 13.03.06 Coordination of benefits shall not be permitted against an indemnity-type policy, an excess insurance policy as defined in Chapter 627.635, *Florida Statutes*, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:

- a) First, benefits of a plan covering a person as an employee, member, or subscriber.
 - b) Second, benefits of a plan of an active worker covering a person as a dependent.
 - c) Third, Medicare benefits.
- 13.03.07 If an individual is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidation Omnibus Budget Reconciliation Act of 1987 (Pub.L. No. 99-272), and also under another Group Health Insurance plan, the following order of benefits applies:
- a) First, the plan covering the person as an employee or as the employee's dependent.
 - b) Second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of COBRA.
- 13.04 For the purpose of determining the applicability and implementing the terms of the Coordination of Benefits provision of this Contract, AvMed may, without the consent of or notice to any person, release to or obtain from any other insurance company, organizations or person, any information, with respect to any Subscriber or applicant for subscription, which AvMed deems to be necessary for such purposes.
- 13.05 Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, AvMed shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts AvMed shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan.
- 13.06 All treatments must be Medically Necessary and comply with all terms, conditions, Limitations, and Exclusions of this Plan even if AvMed is secondary to other coverage and the treatment is covered under the other coverage.
- 13.07 If the amount of the payments made by AvMed is more than it should have paid under the provisions of this Part XIII, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The 'amount of the payments made' includes the reasonable cash value of any benefits provided in the form of services.
- 13.08 In the event the Subscribing Group offers Health Reimbursement Arrangements (HRA) in connection with this Plan, the HRA is intended to pay solely for otherwise un-reimbursed medical expenses. Accordingly, it shall not be considered a group health plan for coordination of benefits purposes, and its benefits shall not be taken into account when determining benefits payable under any other plan.

XIV. SUBROGATION AND RIGHT OF RECOVERY

If AvMed provides health care benefits under this Contract to a Member for injuries or illness for which another party is or may be responsible, then AvMed retains the right to repayment of the full cost of all benefits provided by AvMed on behalf of the Member that are associated with the injury or illness for which another party is or may be responsible. AvMed's rights of recovery apply to any recoveries made by or on behalf of the Member from the following third-party sources, as allowed by law, including but not limited to: payments made by a third-party tortfeasor or any insurance company on behalf of the third-party tortfeasor; any payments or awards under an uninsured or underinsured motorist coverage policy; any worker's compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; any other payments from a source intended

to compensate a Member for injuries resulting from an accident or alleged negligence. For purposes of this Contract, a tortfeasor is any party who has committed injury, or wrongful act done willingly, negligently or in circumstances involving strict liability, but not including breach of contract for which a civil suit can be brought.

- 14.01 Member specifically acknowledges AvMed's right of subrogation. When AvMed provides health care benefits for injuries or illnesses for which a third party is or may be responsible, AvMed shall be subrogated to the Member's rights of recovery against any party to the extent of the full cost of all benefits provided by AvMed, to the fullest extent permitted by law. AvMed may proceed against any party with or without the Member's consent.
- 14.02 Member also specifically acknowledges AvMed's right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when AvMed has provided health care benefits for injuries or illness for which another party is or may be responsible and the Member and/or the Member's representative has recovered any amounts from the third party or any party making payments on the third party's behalf. By providing any benefit under this Contract, AvMed is granted an assignment of the proceeds of any settlement, judgment or other payment received by the Member to the extent of the full cost of all benefits provided by AvMed. AvMed's right of reimbursement is cumulative with and not exclusive of AvMed's subrogation right and AvMed may choose to exercise either or both rights of recovery.
- 14.03 Member and the Member's representatives further agree to:
 - 14.03.01 Notify AvMed promptly and in writing when notice is given to any third party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by the Member that may be the legal responsibility of a third party; and
 - 14.03.02 Cooperate with AvMed and do whatever is necessary to secure AvMed's rights of subrogation and/or reimbursement under this Contract; and
 - 14.03.03 Give AvMed a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from a third party to the extent of the full cost of all benefits associated with injuries or illness provided by AvMed for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement); and
 - 14.03.04 Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due AvMed as reimbursement for the full cost of all benefits associated with injuries or illness provided by AvMed for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by AvMed in writing; and
 - 14.03.05 Do nothing to prejudice AvMed's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery, which specifically attempts to reduce or exclude the full cost of all benefits, provided by AvMed.
- 14.04 AvMed may recover the full cost of all benefits provided by AvMed under this Contract without regard to any claim of fault on the part of the Member, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from AvMed's recovery without the prior express written consent of AvMed. In the event the Member or the Member's representative fails to cooperate with AvMed, the Member shall be responsible for all benefits paid by AvMed in addition to costs and attorney's fees incurred by AvMed in obtaining repayment.

XV. DISCLAIMER OF LIABILITY

- 15.01 Neither Subscribing Group nor its agents, servants or employees, nor any Member is the agent or representative of AvMed, and none of them shall be liable for any acts or omissions of AvMed, its agents or employees or of a Participating Hospital, or a Participating Physician, or any other person or organization with which AvMed has made or hereafter shall make arrangements for the performance of services under this Contract.
- 15.02 Neither Subscribers of Subscribing Group nor their Dependents shall be liable to AvMed or Participating Providers except as specifically set forth herein, provided all procedures set forth herein are followed.
- 15.03 Neither AvMed nor its agents, servants or employees, nor any Member is the agent or representative of the Subscribing Group, and none of them shall be liable for any acts or omissions of Subscribing Group, its agents or employees or any other person representing or acting on behalf of Subscribing Group.
- 15.04 AvMed does not directly employ any practicing physicians nor any Hospital personnel or physicians. These health care providers are independent contractors and are not the agents or employees of AvMed. AvMed shall be deemed not to be a health care provider with respect to any services performed or rendered by any such independent contractors. Participating Providers maintain the physician/patient relationship with Members and are solely responsible for all Medical Services which Participating Providers render to Members. Therefore, AvMed shall not be liable for any negligent act or omission committed by any independent practicing physicians, nurses, or medical personnel, nor any Hospital or health care facility, its personnel, other health care professionals or any of their employees or agents who may, from time to time, provide Medical Services to a Member of AvMed. Furthermore, AvMed shall not be vicariously liable for any negligent act or omission of any of these independent health care professionals who treat a Member of AvMed.
- 15.05 Certain Members may, for personal reasons, refuse to accept procedures or treatment recommended by Participating Physicians. Participating Physicians may regard such refusal to accept their recommendations as incompatible with the continuance of the physician/patient relationship and as obstructing the provision of proper medical care. If a Member refuses to accept the medical treatment or procedure recommended by the Participating Physician and if, in the judgment of the Participating Physician, no professionally acceptable alternative exists or if an alternative treatment does exist but is not recommended by the Participating Physician, the Member shall be so advised.
- 15.06 If the Member continues to refuse the recommended treatment or procedure, AvMed may terminate the Member's coverage under this Contract as set forth in Part IX, Subsection 9.01.05.

XVI. GRIEVANCE PROCEDURE

A grievance is any complaint other than one that involves a request (Claim) for benefits, or an appeal as described in Section 16.02, below. Members have the right to a review of any complaint regarding the services or benefits covered under this Plan. AvMed encourages the informal resolution of complaints. If you have a complaint, you or someone you name to act on your behalf (your authorized representative) may call AvMed's Member Services Department, and a Member Services Representative will try to resolve your complaint for you over the phone. If you ask for a written response, or if the complaint is related to quality of care, AvMed will respond to you in writing. The Member Services Department can also tell you how to name your authorized representative. If a Member's complaint cannot be resolved informally (over the telephone), the complaint may be submitted to AvMed in writing, through the formal Member grievance process. The procedures for filing a grievance are described in 16.01, below.

If a Member has a complaint involving a Claim for benefits, including a benefit denial, he or she may file a written appeal with AvMed. The procedures for filing an appeal are described below, beginning with Section 16.02.

16.01 **Grievances relating to plan services:**

16.01.01 If a Member's complaint cannot be resolved informally over the telephone, the complaint may be submitted in writing to AvMed's Member Services Department. We call this 'filing a grievance'. Grievances must be filed within one year of the occurrence of the event or action that led to the grievance. We will acknowledge and investigate the grievance, and provide a written response advising of the disposition of the grievance within 60 days after receipt of the written grievance. You may submit a grievance in writing to:

AvMed Member Services – North
P.O. Box 823
Gainesville, Florida 32602-0823
Telephone: 1-800-882-8633
Fax: (352) 337-8612

AvMed Member Services – South
P.O. Box 569008
Miami, Florida 33156-9906
Telephone: 1-800-882-8633
Fax: (305) 671-4736

16.01.02 If you are not satisfied with AvMed's final decision, you may contact the Agency for Health Care Administration (AHCA) or the Department of Financial Services (DFS) in writing within 365 days of receipt of AvMed's final decision letter. If you appeal AvMed's decision, your grievance will be reviewed by the Subscriber Assistance Program. You also have the right to contact AHCA or DFS at any time to inform them of an unresolved grievance.

a) The Subscriber Assistance Program will not hear a grievance if you have not completed the entire AvMed grievance process nor if you have instituted an action pending in State or Federal court. If you need further assistance, you may contact:

Subscriber Assistance Program (SAP)
Agency for Health Care Administration
HMO Section
2727 Mahan Drive, Mail Stop 26
Tallahassee, Florida 32308
Telephone 1-888-419-3456, or
850-921-5458

Florida Department of Financial Services
200 East Gaines Street
Tallahassee, Florida 32399
Telephone 1-800-342-2762

16.02 **Pre-Service Claims.**

16.02.01 **Initial Claim.** A Pre-Service Claim shall be deemed to be filed on the date received by AvMed. AvMed shall notify the Claimant of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after AvMed receives the Pre-Service Claim. AvMed may extend this period one time for up to 15 days, provided that AvMed determines that such an extension is necessary due to matters beyond AvMed's control and notifies the Claimant, before the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which AvMed expects to render a decision. If such an extension is necessary because the Claimant failed to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. In the case of a failure by a Claimant to follow AvMed's procedures for filing a Pre-Service Claim, the Claimant shall be notified of the failure and the proper procedures to be followed in filing a Claim for benefits not later than 5 days following such failure. AvMed's period for making the benefit determination shall be tolled from the date on

which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information. If the Claimant fails to supply the requested information within the 45-day period, the Claim shall be denied.

16.02.02 **Appeal.** A Claimant may appeal an Adverse Benefit Determination with respect to a Pre-Service Claim within 180 days of receiving the Adverse Benefit Determination. AvMed shall notify the Claimant, in accordance with Section 16.08, of its determination on review within a reasonable period of time. Such notification shall be provided not later than 30 days after AvMed receives the Claimant's request for review of the Adverse Benefit Determination. You may submit an appeal to:

AvMed Member Services – North
P.O. Box 823
Gainesville, Florida 32602-0823
Telephone: 1-800-882-8633
Fax: (352) 337-8612

AvMed Member Services – South
P.O. Box 569008
Miami, Florida 33156-9906
Telephone: 1-800-882-8633
Fax: (305) 671-4736

16.02.03 If you are not satisfied with AvMed's final decision, you may contact AHCA or DFS in writing within 365 days of receipt of the final decision letter. If you appeal AvMed's decision, your grievance will be reviewed by the Subscriber Assistance Program. You also have the right to contact AHCA or DFS at any time to inform them of an unresolved grievance.

a) The Subscriber Assistance Program will not hear a grievance if you have not completed the entire AvMed grievance process nor if you have instituted an action pending in State or Federal court. If you need further assistance, you may contact:

Subscriber Assistance Program (SAP)
Agency for Health Care Administration
HMO Section
2727 Mahan Drive, Mail Stop 26
Tallahassee, Florida 32308
Telephone 1-888-419-3456, or
850-921-5458

Florida Department of Financial Services
200 East Gaines Street
Tallahassee, Florida 32399
Telephone 1-800-342-2762

16.03 **Urgent Care Claims.**

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

- a) AvMed's receipt of the specified information; or
- b) The end of the period afforded the Claimant to provide the specified additional information.

16.03.02 If the Claimant fails to supply the requested information within the 48-hour period, the Claim shall be denied. AvMed may notify the Claimant of the benefit determination orally or in writing. If the notification is provided orally, a written or electronic notification, meeting the requirements of Section 16.06, shall be provided to the Claimant no later than 3 days after the oral notification.

16.03.03 **Appeal.** A Claimant may appeal an Adverse Benefit Determination with respect to an Urgent Care Claim within 180 days of receiving the Adverse Benefit Determination. AvMed shall notify the Claimant, in accordance with Section 16.08, of AvMed's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after AvMed receives the Claimant's request for review of an Adverse Benefit Determination. You may submit an appeal to:

AvMed Member Services – North
P.O. Box 823
Gainesville, Florida 32602-0823
Telephone: 1-800-882-8633
Fax: (352) 337-8612

AvMed Member Services – South
P.O. Box 569008
Miami, Florida 33156-9906
Telephone: 1-800-882-8633
Fax: (305) 671-4736

16.03.04 If you are not satisfied with AvMed's final decision, you may contact the Florida Agency for Health Care Administration (AHCA) or the Department of Financial Services (DFS) in writing within 365 days of receipt of the final decision letter. If you appeal AvMed's decision, your grievance will be reviewed by the Subscriber Assistance Program. You also have the right to contact the AHCA or DFS at any time to inform them of an unresolved grievance.

a) The Subscriber Assistance Program will not hear a grievance if you have not completed the entire AvMed grievance process nor if you have instituted an action pending in State or Federal court. If you need further assistance, you may contact:

Subscriber Assistance Program (SAP)
Agency for Health Care Administration
HMO Section
2727 Mahan Drive, Mail Stop 26
Tallahassee, Florida 32308
Telephone 1-888-419-3456, or
850-921-5458

Florida Department of Financial Services
200 East Gaines Street
Tallahassee, Florida 32399
Telephone 1-800-342-2762

16.04 **Concurrent Care Claims**

16.04.01 Any reduction or termination by AvMed of Concurrent Care (other than by Plan amendment or termination) before the end of an approved period of time or number of treatments, shall constitute an Adverse Benefit Determination. AvMed shall notify the Claimant, in accordance with Section 16.06, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of the Adverse Benefit Determination before the benefit is reduced or terminated.

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

of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving an Urgent Care Claim or not, shall be made in accordance with the remainder of Part XVI.

16.05 **Post-Service Claims.**

16.05.01 **Initial Claim.** A Post-Service Claim shall be deemed to be filed on the date received by AvMed. AvMed shall notify the Claimant, in accordance with Section 16.06 of AvMed's Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after AvMed receives the Post-Service Claim. AvMed may extend this period one time for up to 15 days, provided that AvMed determines that such an extension is necessary due to matters beyond AvMed's control and notifies the Claimant, before the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which AvMed expects to render a decision. If such an extension is necessary because the Claimant failed to submit the information necessary to decide the Post-Service Claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. AvMed's period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information. If the Claimant fails to supply the requested information within the 45-day period, the Claim shall be denied.

16.05.02 **Appeal.** A Claimant may appeal an Adverse Benefit Determination with respect to a Post-Service Claim within 180 days of receiving the Adverse Benefit Determination. AvMed shall notify the Claimant, in accordance with Section 16.08, of AvMed's determination on review within a reasonable period of time. Such notification shall be provided not later than 60 days after AvMed receives the Claimant's request for review of the Adverse Benefit Determination. You may submit an appeal to:

AvMed Member Services – North
P.O. Box 823
Gainesville, Florida 32602-0823
Telephone: 1-800-882-8633
Fax: (352) 337-8612

AvMed Member Services – South
P.O. Box 569008
Miami, Florida 33156-9906
Telephone: 1-800-882-8633
Fax: (305) 671-4736

16.05.03 If you are not satisfied with AvMed's final decision, you may contact AHCA or DFS in writing within 365 days of receipt of the final decision letter. If you appeal AvMed's decision, your grievance will be reviewed by the Subscriber Assistance Program. You also have the right to contact AHCA or DFS at any time to inform them of an unresolved grievance.

a) The Subscriber Assistance Program will not hear a grievance if you have not completed the entire AvMed grievance process nor if you have instituted an action pending in State or Federal court. If you need further assistance, you may contact:

Subscriber Assistance Program (SAP)
Agency for Health Care Administration
HMO Section
2727 Mahan Drive, Mail Stop 26
Tallahassee, Florida 32308
Telephone 1-888-419-3456, or
850-921-5458

Florida Department of Financial Services
200 East Gaines Street
Tallahassee, Florida 32399
Telephone 1-800-342-2762

- 16.06 **Manner and content of initial claims determination notification.** AvMed shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Claimant, the following:
- 16.06.01 The specific reasons for the Adverse Benefit Determination.
 - 16.06.02 Reference to the specific Plan provisions on which the determination is based.
 - 16.06.03 A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary.
 - 16.06.04 A description of AvMed's review procedures and the time limits applicable to such procedures, including, when applicable, a statement of the Claimant's right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), following an Adverse Benefit Determination on final review.
 - 16.06.05 If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy shall be provided free of charge to the Claimant upon request.
 - 16.06.06 If the Adverse Benefit Determination is based on whether the treatment or service is experimental and/or investigational or not Medically Necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request.
 - 16.06.07 In the case of an Adverse Benefit Determination involving an Urgent Care Claim, a description of the expedited review process applicable to such Claim.
- 16.07 **Review procedure upon appeal.** AvMed's appeal procedures shall include the following substantive procedures and safeguards:
- 16.07.01 Claimant may submit written comments, documents, records, and other information relating to the Claim.
 - 16.07.02 Upon request and free of charge, the Claimant shall have reasonable access to and copies of any Relevant Documents.
 - 16.07.03 The appeal shall take into account all comments, documents, records, and other information the Claimant submitted relating to the Claim, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.
 - 16.07.04 The appeal shall be conducted by an appropriate named fiduciary of AvMed who is neither the individual who made the initial Adverse Benefit Determination nor the subordinate of such individual. Such person shall not defer to the initial Adverse Benefit Determination.
 - 16.07.05 In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, medication, or other item is experimental and/or investigational or not Medically Necessary, the appropriate named fiduciary shall consult with a Health Professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
 - 16.07.06 The appeal shall provide for the identification of medical or vocational experts whose advice was obtained on behalf of AvMed in connection with a Claimant's Adverse Benefit

Determination, without regard to whether the advice was relied upon in making the Adverse Benefit Determination.

16.07.07 The appeal shall provide that the Health Professional engaged for purposes of a consultation in Subsection 16.07.05 shall be an individual who is neither an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

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

- a) Request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and
- b) All necessary information, including AvMed's benefit determination on review, shall be transmitted between AvMed and the Claimant by telephone, facsimile, or other available similarly expeditious methods.

16.08 **Manner and content of appeal notification.** AvMed shall provide a Claimant with written or electronic notification of AvMed's benefit determination upon review.

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

- a) The specific reasons for the Adverse Benefit Determination.
- b) Reference to the specific Plan provisions on which the Adverse Benefit Determination is based.
- c) A statement that the Claimant is entitled to receive, upon request, and free of charge, reasonable access to, and copies of any Relevant Documents.
- d) A statement describing any voluntary appeal procedures offered by AvMed and the Claimant's right to obtain the information about such procedures and a statement of the Claimant's right to bring an action under ERISA Section 502(a) when applicable.
- e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy shall be provided free of charge to the Claimant upon request.
- f) If the Adverse Benefit Determination is based on whether the treatment or service is experimental and/or investigational or not Medically Necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation shall be provided free of charge upon request.

XVII. MISCELLANEOUS

17.01 Applicability of law. The provisions of this Contract shall be deemed to have been modified by the parties, and shall be interpreted, so as to comply with the laws and regulations of the State of Florida and the United States.

- 17.02 Assignment. This Contract, and all rights and benefits related thereto, may not be assigned by the Subscribing Group or the Members without written consent of AvMed.
- 17.03 Certificate of Coverage. AvMed shall provide a copy of the Certificate of Coverage for each Subscriber. No changes or amendments to this Contract shall be valid unless approved by an executive officer of AvMed and endorsed herein or attached hereto. No agent has authority to change this Contract or to waive any of its provisions.
- 17.04 Circumstances not reasonably within the control of AvMed. In the event of circumstances not reasonably within the control of AvMed, including major disasters and under such circumstances as complete or partial destruction of facilities, an act of God, war, riot, civil insurrection, disability of a significant part of Hospital or participating medical personnel or similar causes, if the rendition of Medical Services and Hospital Services provided under this Contract is delayed or rendered impractical, neither AvMed, Participating Providers, nor any physician shall have any liability or obligation on account of such delay or failure to provide services; however, AvMed shall make a good faith effort to arrange for the timely provision of covered services during such event.
- 17.05 Clerical errors. Clerical errors shall neither deprive any individual Member of any benefits or coverage provided under this Group Contract nor shall such errors act as authorization of benefits or coverage for the Member that is not otherwise validly in force. Retroactive adjustments in coverage, for clerical errors or otherwise will only be done for up to a 60 day period from the date of notification. Refunds of premiums are done for up to a 60 day period from the date of notification. Refunds of premiums are limited to a total of 60 days from the date of notification of the event, provided there are no Claims incurred subsequent to the effective date of such event.
- 17.06 Contracting parties. By executing this Contract, Subscribing Group and AvMed agree to make the Medical Services and Hospital Services specified herein available to persons who are eligible under the provisions of Part IV. However, the delivery of benefits and services covered in this Contract shall be subject to the provisions, Limitations, and Exclusions set forth herein and any amendments, modifications, and Contract termination provisions specified herein and by the mutual agreement between AvMed and Subscribing Group, without the consent or concurrence of the Members. By electing or accepting Medical Services and Hospital or other benefits hereunder, all Members legally capable of contracting and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.
- 17.07 Contract review. Subscribing Group may, if this Contract is not satisfactory for any reason, return this Contract within 3 days after receipt and receive a full refund of the deposit paid, if any, unless the services of AvMed were utilized during the 3 days. If this Contract is not returned within 3 days after receipt, then this Contract shall be deemed to have been accepted.
- 17.08 Entirety of Contract. This Agreement and all applicable schedules, exhibits, riders, amendments and any other attachments and endorsements, constitute the entire Contract between the Subscribing Group and AvMed. No modification (or oral representation) of this Group Contract shall be of any force or effect unless it is in writing and signed by both parties.
- 17.09 ERISA. When this Contract is purchased by the Subscribing Group to provide benefits under a welfare plan governed by ERISA, AvMed shall be considered a fiduciary to the extent that it performs any discretionary functions on behalf of the Plan. If a Member has questions about the group's welfare plan, the Member should contact the Subscribing Group.
- 17.10 Gender. Whenever used, the singular shall include the plural and the plural the singular and the use of any gender shall include all genders.
- 17.11 Identification cards. Cards issued by AvMed to Members pursuant to this Contract are for purposes of identification only. Possession of an AvMed identification card confers no right to health services or

other benefits under this Contract. To be entitled to such services or benefits the holder of the card must, in fact, be a Member on whose behalf all applicable charges under this Contract have actually been paid and accepted by AvMed.

- 17.12 Membership Application. Members or applicants for membership shall complete and submit to AvMed such applications or other forms or statements as AvMed may reasonably request. If Member or applicant fails to provide accurate information which AvMed deems material then, upon ten days written notice, AvMed may deny coverage and/or membership to such individual. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony, punishable as provided by the *Florida Statutes*.
- 17.13 Non-waiver. The failure of AvMed to enforce any of the provisions of this Contract or to exercise any options herein provided or to require timely performance by any Member or Subscribing Group of any of the provisions herein, shall not be construed to be a waiver of such provisions nor shall it affect the validity of this Contract or any part thereof or the right of AvMed to thereafter enforce each and every such provision.
- 17.14 Notice. Any notice intended for and directed to a party to this Contract, unless otherwise expressly provided, should be sent by United States mail, postage prepaid, addressed as follows:
- If to AvMed, to: AvMed
P. O. Box 749
Gainesville, Florida 32602-0749
- (OR if from a Member to AvMed, see the Member's Service Area address listed on Page i.)
- If to a Member: to the last address provided by the Member and actually received by AvMed on the enrollment application or change of address notification.
- If to Subscribing Group: To the address provided in the Group Master Application.
- 17.15 Plan administration. AvMed may from time to time adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of this Contract.
- 17.16 Premium tax/surcharge. If any government entity shall impose a premium tax or surcharge, then the sums due from the Subscribing Group under the terms of this Contract shall be increased by the amount of such premium tax or surcharge.
- 17.17 Rate letter. The 'rate letter' is AvMed's formal notice to the Subscribing Group of the premium rates applicable to the Subscribing Group, the conditions under which the rates are valid, the premium payment terms and due dates, the additional charge which will apply to all late premium payments, AvMed's reservation of the right to adjust (re-rate) the premium quote to account for changes in the group size or in the data supplied by the Subscribing Group to AvMed, the applicable employer-employee contribution to the premium payment and the charge for other optional, supplemental benefits selected by the Subscribing Group, if any.
- 17.18 Third party beneficiary. This Contract is entered into exclusively between the Subscribing Group and AvMed. This Contract is intended only to benefit the Subscribing Group and the Members and does not confer any rights on any other third parties.
- 17.19 Waiver. A Claim that has not been timely filed with AvMed within one year of date of service shall be considered waived.



**AVMED, INC. d/b/a AVMED Health Plans
Group Medical and Hospital Service Contract
Group Master Application**

Contract Number(s): **106421**
 Subscribing Group Name: **City of Miami Gardens**
 Effective Date: **01/01/11**

Group Contract

This Group Contract provides the benefits listed below:

<u>Identifier</u>	<u>Description</u>
AV-City of Miami Gardens-10	Summary of Benefits
AV-Open Access-09	Open Access
AV-LG-RX-2x-10/20/30/75/50%-B-09	Prescription Drug
AV-G100-MHPH-09	IP Mental Health
AV-G100-SAPH-09	Substance Abuse
AV-G100-DME-2000-R-06	Durable Med. Equip.
AV-G100-ETP-R-97	ETOP
AV-Mammogram-05	Mammogram

Eligibility

Active Employees (Class 1) are required to work 40 hours per week to become eligible for coverage under this Contract. Employees will become eligible for coverage on the first of the month following 30 days of employment.

Active Employees (Class 2) are required to work 40 hours per week to become eligible for coverage under this Contract. Employees will become eligible for coverage on the first day of employment.

Termination

For Active Employees (Class 1), termination of coverage under this Contract shall become effective End of Month.

For Active Employees (Class 2), termination of coverage under this Contract shall become effective End of Month.

Monthly Membership Charges

Subscriber Only	\$474.45
Subscriber plus Spouse	\$901.45
Subscriber plus One Dependent (No Spouse)	\$901.45
Subscriber plus Two or More Dependents	\$1,280.99
Subscriber plus Spouse and One or More Dependents.....	\$1,280.99

NOTE

- Pending City of Miami Gardens' approval.
- Benefit plan will be administered in accordance with the requirements of Health Care Reform.

AVMED, INC. d/b/a AVMED Health Plans
Group Medical and Hospital Service Contract
Group Master Application

Agreement

This contract is issued in consideration of the Master Application of the Subscribing Group for group medical and hospital services and the monthly prepayment subscription charges and the mutual promises and benefits between AVMED, Inc. d/b/a AVMED Health Plans and the Subscribing Group. This Contract shall remain in effect for a period of twelve (12) months from the effective date of **January 1, 2011** and may be renewed annually, not later than the anniversary date, upon mutual agreement of the parties. This Contract period begins at 12:01 a.m. Eastern Standard Time on the effective date or on the anniversary date, if a renewal. The Contract shall be governed by Chapter 641, Florida Statutes, and other applicable State and Federal laws.

The first monthly payment is due on **January 1, 2011**. Subsequent payments are due on the 1st day of each month thereafter.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

The provisions contained in the Schedule of Benefits applicable to this Contract and all Exhibits and Amendments executed by the parties and attached hereto are, by reference, made a part of this Contract.

AGREED TO AND ACCEPTED BY the parties the day and year hereinafter written.

The Effective Date of this Contract is January 1, 2011.

Subscribing Group:

City of Miami Gardens

AVMED, Inc. d/b/a AVMED Health Plans

By: _____
Signature

By: _____
Signature

Name

Pat Nelson
Name

Title

Director of Client Service
Title

Date: _____

Date: _____

NOTE

- Pending City of Miami Gardens' approval.
- Benefit plan will be administered in accordance with the requirements of Health Care Reform.

Benefit Summary



CITY OF MIAMI GARDENS	SCHEDULE OF BENEFITS	COST TO MEMBER
OUT-OF-POCKET MAXIMUM Per Calendar Year		\$1,500 INDIVIDUAL \$3,000 FAMILY
AVMED PRIMARY CARE PHYSICIAN	Services at Participating Physicians' offices include, but are not limited to: <ul style="list-style-type: none"> ▪ Routine office visits / annual well-woman examination when performed by Primary Care Physician ▪ Pediatric care and well-child care ▪ Periodic health evaluation and immunizations ▪ Diagnostic imaging, laboratory or other diagnostic services ▪ Minor surgical procedures ▪ Vision and hearing screenings for children under 18 	\$15 per visit
MATERNITY CARE	<ul style="list-style-type: none"> ▪ Initial visit ▪ Subsequent visits 	\$15 Co-payment NO CHARGE
AVMED SPECIALITY HEALTH CARE PHYSICIAN SERVICES	<ul style="list-style-type: none"> ▪ Office visits ▪ Annual well-woman examination when performed by a participating Specialty Health Care Physician Additional charges will apply if Outpatient Diagnostic Tests are performed in the Specialist's office.	\$15 per visit
HOSPITAL	Inpatient care at Participating Hospitals includes: <ul style="list-style-type: none"> ▪ Room and board - unlimited days (semi-private) ▪ Physicians', specialists' and surgeons' services ▪ Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication ▪ Intensive care unit and other special units, general and special duty nursing ▪ Laboratory and diagnostic imaging ▪ Required special diets ▪ Radiation and inhalation therapies 	NO CHARGE
OUTPATIENT SERVICES	<ul style="list-style-type: none"> ▪ Outpatient surgeries, including cardiac catheterizations and angioplasty ▪ Outpatient therapeutic services, including: <ul style="list-style-type: none"> ▪ Drug infusion therapy ▪ Injectable Drugs (Co-payment for Injectable Drug waived if incidental to same-day drug infusion therapy) ▪ Preventive and diagnostic colonoscopies 	NO CHARGE \$100 Co-payment \$75 Co-payment
OUTPATIENT DIAGNOSTIC TESTS	<ul style="list-style-type: none"> ▪ CAT Scan, PET Scan, MRI ▪ Other diagnostic imaging tests Charges for office visits will also apply if services are performed in a Specialist's office.	\$25 per test \$10 per test
EMERGENCY SERVICES	An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. <ul style="list-style-type: none"> ▪ Emergency services at Participating Hospitals ▪ Emergency services at non-participating Hospitals, facilities and/or physicians 	\$150 Co-payment
<p>AvMed must be notified within 24 hours of inpatient admission following emergency services or as soon as reasonably possible</p>		

Benefit Summary, continued

URGENT/IMMEDIATE CARE	<ul style="list-style-type: none"> ▪ Medical Services at a participating Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office \$40 Co-payment ▪ Medical Services at a participating retail clinic \$15 per visit ▪ Medical Services at a non-participating Urgent/Immediate Care facility or non-participating retail clinic \$60 Co-payment
FAMILY PLANNING	<ul style="list-style-type: none"> ▪ Voluntary family planning services \$15 per visit ▪ Sterilization (In addition to any Outpatient Facility charge) \$250 Co-payment
ALLERGY TREATMENTS	<ul style="list-style-type: none"> ▪ Injections \$10 per visit ▪ Skin testing \$50 per course of testing
AMBULANCE	<ul style="list-style-type: none"> ▪ Ambulance transport for emergency services \$100 Co-payment ▪ Non-emergent ambulance services are covered when the skill of medically trained personnel is required and the Member cannot be safely transported by other means
PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES	<ul style="list-style-type: none"> ▪ Short-term physical, speech or occupational therapy for acute conditions \$15 per visit <p>Coverage is limited to 30 visits per calendar year for all services combined</p>
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER	<ul style="list-style-type: none"> ▪ Applied Behavior Analysis services \$15 per visit ▪ Physical, speech or occupational therapy for the treatment of Autism Spectrum Disorder \$15 per visit <p>Coverage for all services related to Autism Spectrum Disorder is limited to \$36,000 annually and may not exceed \$200,000 in total benefits.</p>
SKILLED NURSING FACILITIES AND REHABILITATION CENTERS	<ul style="list-style-type: none"> ▪ Up to 20 days post-hospitalization care per calendar year when prescribed by physician and authorized by AvMed \$50 per day
CARDIAC REHABILITATION	<p>Cardiac rehabilitation is covered for the following conditions:</p> <ul style="list-style-type: none"> ▪ Acute myocardial infarction \$20 per visit ▪ Percutaneous transluminal coronary angioplasty (PTCA) Benefits limited to \$1,500 per calendar year ▪ Repair or replacement of heart valves ▪ Coronary artery bypass graft (CABG), or ▪ Heart transplant <p>Coverage is limited to 18 visits per calendar year</p>
HOME HEALTH CARE	<ul style="list-style-type: none"> ▪ Limited to 60 skilled visits per calendar year NO CHARGE
DURABLE MEDICAL EQUIPMENT AND ORTHOTIC APPLIANCES	<p>Equipment includes:</p> <ul style="list-style-type: none"> ▪ Hospital beds \$50 per episode of illness ▪ Walkers ▪ Crutches ▪ Wheelchairs <p>Orthotic appliances are limited to:</p> <ul style="list-style-type: none"> ▪ Leg, arm, back and neck custom-made braces Benefits limited to \$500 per calendar year
PROSTHETIC DEVICES	<p>Prosthetic devices are limited to:</p> <ul style="list-style-type: none"> ▪ Artificial limbs ▪ Artificial joints ▪ Ocular prostheses NO CHARGE

FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-88-AVMED (1-800-882-8633)

This Schedule of Benefits is not a contract. For specific information on Benefits, Exclusions and Limitations, please consult your AvMed Group Medical and Hospital Service Contract.

PLEASE NOTE: This benefit plan will be administered in accordance with the requirements of Health Care Reform.

Prescription Medication Benefits



\$10/20/30/75/50% CO-PAYMENT with Contraceptives

DEFINITIONS

Brand medication means a Prescription Drug that is usually manufactured and sold under a name or trademark by a pharmaceutical manufacturer or a medication that is identified as a Brand medication by AvMed. AvMed delegates determination of Generic/Brand status to our Pharmacy Benefits Manager.

Brand Additional Charge means the additional charge that must be paid if you choose a Brand medication when a Generic equivalent is available. The charge is the difference between the cost of the Brand medication and the Generic medication. This charge must be paid in addition to the applicable Non-Preferred Brand Co-payment. However, if the prescribing physician or other Participating Provider authorized to prescribe medications within the scope of his or her license indicates on the prescription Brand medically necessary or dispense as written for a medication for which there is a generic equivalent, the Brand medication shall be dispensed for the applicable Non-Preferred Brand Co-payment only.

Cost-sharing Medications are those medications, as designated by AvMed, which were designed to improve the quality of life by treating relatively minor non-life threatening conditions or which have multiple generic or non-prescription therapeutic alternatives. Such medications are subject to Co-insurance and coverage is limited as outlined below.

Dental-specific Medication is medication used for dental-specific purposes, including but not limited to fluoride medications and medications packaged and labeled for dental-specific purposes.

Formulary List means the listing of preferred and non-preferred medications as determined by AvMed's Pharmacy and Therapeutics Committee based on clinical efficacy, relative safety and cost in comparison to similar medications within a therapeutic class. This multi-tiered list establishes different levels of Co-payment for medications within therapeutic classes. As new medications become available, they may be considered excluded until they have been reviewed by AvMed's Pharmacy and Therapeutics Committee.

Generic medication means a medication that has the same active ingredient as a Brand medication or is identified as a Generic medication by AvMed's Pharmacy Benefits Manager.

Injectable Medication is a medication that has been approved by the Food and Drug Administration (FDA) for administration by one or more of the following routes: intramuscular injection, intravenous injection, intravenous infusion, subcutaneous injection, intrathecal injection, intrarticular injection, intracavernous injection or intraocular injection. Prior authorization is required for all Injectable Medications.

Maintenance Medication is a medication that has been approved by the FDA, for which the duration of therapy can reasonably be expected to exceed one year.

Participating Pharmacy means a pharmacy (retail, mail order or specialty pharmacy) that has entered into an agreement with AvMed to provide Prescription Drugs to AvMed Members and has been designated by AvMed as a Participating Pharmacy.

Prescription Drug means a medication that has been approved by the FDA and that can only be dispensed pursuant to a prescription according to state and federal law.

Prior Authorization means the process of obtaining approval for certain Prescription Drugs (prior to dispensing) according to AvMed's guidelines. The prescribing physician must obtain approval from AvMed. The list of Prescription Drugs requiring Prior Authorization is subject to periodic review and modification by AvMed. A copy of the list of medications requiring Prior Authorization and the applicable criteria are available from Member Services or from the AvMed website.

HOW DOES YOUR RETAIL PRESCRIPTION COVERAGE WORK?

To obtain your Prescription Drug, take your prescription to, or have your physician call, an AvMed Participating Pharmacy. Your physician should submit prescriptions for Injectable Medications to AvMed's specialty pharmacy. Present your prescription along with your AvMed identification card. Pay the following Co-payment (as well as the Brand Additional Charge if you choose a Brand product when a Generic equivalent is available).

Tier 1	Preferred Generic Medications:	\$ 10.00	Co-payment
Tier 2	Preferred Brand Medications:	\$ 20.00	Co-payment
Tier 3	Non-Preferred Brand or Generic Medications:	\$ 30.00	Co-payment
Tier 4	Injectable Medications:	\$ 75.00	Co-payment
Tier 5	Cost-sharing Medications:	50%	Co-Insurance

ORDERING YOUR PRESCRIPTIONS THROUGH THE MAIL

Mail service is a benefit option for maintenance medications needed for chronic or long-term health conditions. It is best to get an initial prescription filled at your retail pharmacy. Ask your physician for an additional prescription for up to a 90-day supply of your medication to be ordered through mail service. Up to 3 refills are allowed per prescription. Pay the following Co-payment (as well as the Brand Additional Charge if you choose a Brand product when a Generic equivalent is available).

Tier 1	Preferred Generic Medications:	\$ 20.00	Co-payment
Tier 2	Preferred Brand Medications:	\$ 40.00	Co-payment
Tier 3	Non-Preferred Brand or Generic Medications:	\$ 60.00	Co-payment
Tier 4	Injectable Medications are not available through mail service		
Tier 5	Cost-sharing Medications are not available through mail service		

Prescription Medication Benefits, continued

WHAT IS COVERED?

- Your Prescription Drug coverage includes outpatient medications (including contraceptives) that require a prescription and are prescribed by your AvMed physician in accordance with AvMed's coverage criteria. AvMed reserves the right to make changes in coverage criteria for covered products and services. Coverage criteria are medical and pharmaceutical protocols used to determine payment of products and services and are based on independent clinical practice guidelines and standards of care established by government agencies and medical/pharmaceutical societies.
- Your Prescription Drug coverage may require Prior Authorization, including the Progressive Medication Program, for certain covered medications. The Progressive Medication Program encourages the use of therapeutically-equivalent lower-cost medications by requiring certain medications to be utilized to treat a medical condition prior to approving another medication for that condition. This includes the first-line use of preferred medications that are proven to be safe and effective for a given condition and can provide the same health benefit as more expensive non-preferred medications at a lower cost.
- Your retail Prescription Drug coverage includes up to a 30-day supply of a medication for the listed Co-payment. Your prescription may be refilled via retail or mail order after 75% of your previous fill has been used and subject to a maximum of 13 refills per year. You also have the opportunity to obtain a 90-day supply of medications used for chronic conditions including, but not limited to asthma, cardiovascular disease, and diabetes from the retail pharmacy for the applicable Co-payment per 30-day supply. However, Prior Authorization may be required for covered medications.
- Your mail-order Prescription Drug coverage includes up to a 90-day supply of a routine maintenance medication for the listed Co-payment. If the amount of medication is less than a 90-day supply, you will still be charged the listed mail order Co-payment.
- Your Injectable Medication coverage extends to many injectable medications approved by the FDA. These medications must be prescribed by a physician and dispensed by a retail or specialty pharmacy. The Co-payment levels for Injectable Medications apply regardless of provider. This means that you are responsible for the appropriate Co-payment whether you receive your Injectable Medication from the pharmacy, at the physician's office or during home health visits. Injectable Medications are limited to a 30-day supply.
- Your Prescription Drug coverage includes coverage for injectable contraceptives. There is a Co-payment of \$30 for each injection. If there is an office visit associated with the injection, there will be an additional Co-payment required for the office visit.
- Quantity limits are set in accordance with FDA approved prescribing limitations, general practice guidelines supported by medical specialty organizations, and/or evidence-based, statistically valid clinical studies without published conflicting data. This means that a medication-specific quantity limit may apply for medications that have an increased potential for over-utilization or an increased potential for a Member to experience an adverse effect at higher doses.

QUESTIONS? Call your AvMed Member Services Department at: 1-800-88-AvMed (1-800-882-8633)

EXCLUSIONS AND LIMITATIONS

- Medications which do not require a prescription (i.e. over-the-counter medications) or when a non-prescription alternative is available, unless otherwise indicated on AvMed's Formulary List.
- Medications not included on AvMed's Formulary List.
- Medical supplies, including therapeutic devices, dressings, appliances and support garments
- Replacement Prescription Drug products resulting from a lost, stolen, expired, broken or destroyed prescription order or refill
- Diaphragms and other contraceptive devices
- Fertility drugs
- Medications or devices for the diagnosis or treatment of sexual dysfunction
- Dental-specific Medications for dental purposes, including fluoride medications
- Prescription and non-prescription vitamins and minerals except prenatal vitamins
- Nutritional supplements
- Immunizations
- Allergy serums, medications administered by the Attending Physician to treat the acute phase of an illness and chemotherapy for cancer patients are covered in accordance with the Group Medical and Hospital Service Contract and may be subject to Co-payments or Co-insurance as outlined on the Schedule of Benefits
- Investigational and experimental drugs (except as required by Florida statute)
- Cosmetic products, including, but not limited to, hair growth, skin bleaching, sun damage and anti-wrinkle medications
- Nicotine suppressants and smoking cessation products and services
- Prescription and non-prescription appetite suppressants and products for the purpose of weight loss
- Compounded prescriptions, except pediatric preparations
- Medications and immunizations for non-business related travel, including Transdermal Scopolamine

Filling a prescription at a pharmacy is not a claim for benefits and is not subject to the Claims and Appeals procedures under ERISA. However, any medicines that require Prior authorization will be treated as a claim for benefits subject to the Claims and Appeals Procedures, as outlined in the Group Medical and Hospital Service Contract.



Addendum

Coverage for Mammograms – Waiver of Co-payment

If selected, the following provision is hereby modified for an additional premium:

Section 10.28 of the AvMed Health Plans Group Medical and Hospital Service Contract is amended to state:

Mammograms are covered in accordance with *Florida Statutes*: one baseline mammogram is covered for female Members between the ages of 35 and 39; a mammogram is available every two years for female Members between the ages of 40 and 49; and a mammogram is available every year for female Members aged 50 and older.

In addition, one or more mammograms a year are available when based upon a physician's recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of 30. **This coverage will not be subject to diagnostic imaging Co-payments.**



Amendment

Durable Medical Equipment

If selected, the following coverage is hereby modified, for an additional premium.

DURABLE MEDICAL EQUIPMENT

- Benefits are limited to a maximum of \$2,000 per contract year*.

All other coverage provisions, including co-payment, limitations and exclusions remain as stated in the Certificate of Coverage or Schedule of Co-Payments.

*For the treatment of diabetes, coverage for an infusion pump will not apply toward the annual maximum limitation and shall not be subject to the durable medical equipment benefit limitation.



Amendment

ELECTIVE TERMINATION OF PREGNANCY

If selected, the following optional coverage is hereby added:

The AvMed Health Plan Group Medical and Hospital Service Contract is amended to state:

- Elective termination of pregnancy will be a covered benefit if the services and treatment are provided by an AvMed participating provider in an AvMed participating facility. There shall be a physician copayment of \$100.00 in addition to the applicable facility copayment.

Amendment



Mental Health Services

As of the effective date, outpatient and inpatient mental health services are covered, when Medically Necessary, subject to the following Member cost sharing responsibility:

- Outpatient mental health services are covered subject to the Member's cost sharing responsibility for specialist services.
- Inpatient or partial hospitalization for mental health services is covered when a Member is admitted to a Participating Hospital or Health Care Facility. Coverage is subject to the Member's cost sharing responsibility for inpatient Hospital Services.

Prior authorization is required for mental health services. Please consult the Schedule of Benefits for Member cost sharing responsibility and Deductible information, if applicable. For further information, contact AvMed at 1-800-882-8633.

Amendment



Substance Abuse Services

As of the effective date, outpatient and inpatient substance abuse services are covered, when Medically Necessary, subject to the following Member cost sharing responsibility:

- Outpatient substance abuse services are covered subject to the Member's cost sharing responsibility for specialist services.
- Inpatient or partial hospitalization for substance abuse services is covered when a Member is admitted to a Participating Hospital or Health Care Facility. Coverage is subject to the Member's cost sharing responsibility for inpatient Hospital Services.

Prior authorization is required for substance abuse services. Please consult the Schedule of Benefits for Member cost sharing responsibility and Deductible information, if applicable. For further information, contact AvMed at 1-800-882-8633.



**AVMED, INC. d/b/a AVMED Health Plans
Group Medical and Hospital Service Contract
Group Master Application**

Contract Number(s): **106422**
 Subscribing Group Name: **City of Miami Gardens**
 Effective Date: **01/01/11**

Group Contract

This Group Contract provides the benefits listed below:

<u>Identifier</u>	<u>Description</u>
POS-500-30-3000	Summary of Benefits
AV-POS Open Access-09	Open Access
AV-Open Access-09	Open Access
AV-City of Miami Gardens-10	Summary of Benefits
AV-LG-RX-2x-10/20/30/75/50%-B-09	Prescription Drug
RI-MH-POS-5309	IP Mental Health
RI-SA-POS-5308-09	Substance Abuse
AV-G100-DME-2000-R-06	Durable Med. Equip.
AV-G100-ETP-R-97	ETOP
AV-Mammogram-05	Mammogram

Eligibility

Active Employees (Class 1) are required to work 40 hours per week to become eligible for coverage under this Contract. Employees will become eligible for coverage on the first of the month following 30 days of employment.

Active Employees (Class 2) are required to work 40 hours per week to become eligible for coverage under this Contract. Employees will become eligible for coverage on the first day of employment.

Termination

For Active Employees (Class 1), termination of coverage under this Contract shall become effective End of Month.

For Active Employees (Class 2), termination of coverage under this Contract shall become effective End of Month.

Monthly Membership Charges

Subscriber Only	\$531.23
Subscriber plus Spouse	\$1,009.33
Subscriber plus One Dependent (No Spouse)	\$1,009.33
Subscriber plus Two or More Dependents	\$1,434.30
Subscriber plus Spouse and One or More Dependents.....	\$1,434.30

NOTE

- Pending City of Miami Gardens' approval.
- Benefit plan will be administered in accordance with the requirements of Health Care Reform.

Handwritten signature

AVMED, INC. d/b/a AVMED Health Plans
Group Medical and Hospital Service Contract
Group Master Application

Agreement

This contract is issued in consideration of the Master Application of the Subscribing Group for group medical and hospital services and the monthly prepayment subscription charges and the mutual promises and benefits between AVMED, Inc. d/b/a AVMED Health Plans and the Subscribing Group. This Contract shall remain in effect for a period of twelve (12) months from the effective date of January 1, 2011 and may be renewed annually, not later than the anniversary date, upon mutual agreement of the parties. This Contract period begins at 12:01 a.m. Eastern Standard Time on the effective date or on the anniversary date, if a renewal. The Contract shall be governed by Chapter 641, Florida Statutes, and other applicable State and Federal laws.

The first monthly payment is due on January 1, 2011. Subsequent payments are due on the 1st day of each month thereafter.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

The provisions contained in the Schedule of Benefits applicable to this Contract and all Exhibits and Amendments executed by the parties and attached hereto are, by reference, made a part of this Contract.

AGREED TO AND ACCEPTED BY the parties the day and year hereinafter written.

The Effective Date of this Contract is January 1, 2011.

Subscribing Group:

City of Miami Gardens

AVMED, Inc. d/b/a AVMED Health Plans

By: Signature

By: Signature

Name

Pat Nelson
Name

Title

Director of Client Service
Title

Date:

Date:

NOTE

- Pending City of Miami Gardens' approval.
Benefit plan will be administered in accordance with the requirements of Health Care Reform.

Benefit Summary



CITY OF MIAMI GARDENS	SCHEDULE OF BENEFITS	COST TO MEMBER
OUT-OF-POCKET MAXIMUM Per Calendar Year		\$1,500 INDIVIDUAL \$3,000 FAMILY
AVMED PRIMARY CARE PHYSICIAN	Services at Participating Physicians' offices include, but are not limited to: <ul style="list-style-type: none"> ▪ Routine office visits / annual well-woman examination when performed by Primary Care Physician ▪ Pediatric care and well-child care ▪ Periodic health evaluation and immunizations ▪ Diagnostic imaging, laboratory or other diagnostic services ▪ Minor surgical procedures ▪ Vision and hearing screenings for children under 18 	\$15 per visit
MATERNITY CARE	<ul style="list-style-type: none"> ▪ Initial visit ▪ Subsequent visits 	\$15 Co-payment NO CHARGE
AVMED SPECIALITY HEALTH CARE PHYSICIAN SERVICES	<ul style="list-style-type: none"> ▪ Office visits ▪ Annual well-woman examination when performed by a participating Specialty Health Care Physician <p>Additional charges will apply if Outpatient Diagnostic Tests are performed in the Specialist's office.</p>	\$15 per visit
HOSPITAL	Inpatient care at Participating Hospitals includes: <ul style="list-style-type: none"> ▪ Room and board - unlimited days (semi-private) ▪ Physicians', specialists' and surgeons' services ▪ Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication ▪ Intensive care unit and other special units, general and special duty nursing ▪ Laboratory and diagnostic imaging ▪ Required special diets ▪ Radiation and inhalation therapies 	NO CHARGE
OUTPATIENT SERVICES	<ul style="list-style-type: none"> ▪ Outpatient surgeries, including cardiac catheterizations and angioplasty ▪ Outpatient therapeutic services, including: <ul style="list-style-type: none"> ▪ Drug infusion therapy ▪ Injectable Drugs (Co-payment for Injectable Drug waived if incidental to same-day drug infusion therapy) ▪ Preventive and diagnostic colonoscopies 	NO CHARGE \$100 Co-payment \$75 Co-payment
OUTPATIENT DIAGNOSTIC TESTS	<ul style="list-style-type: none"> ▪ CAT Scan, PET Scan, MRI ▪ Other diagnostic imaging tests <p>Charges for office visits will also apply if services are performed in a Specialist's office.</p>	\$25 per test \$10 per test
EMERGENCY SERVICES	An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. <ul style="list-style-type: none"> ▪ Emergency services at Participating Hospitals ▪ Emergency services at non-participating Hospitals, facilities and/or physicians 	\$150 Co-payment
AvMed must be notified within 24 hours of inpatient admission following emergency services or as soon as reasonably possible		

Benefit Summary, continued

URGENT/IMMEDIATE CARE	<ul style="list-style-type: none"> ▪ Medical Services at a participating Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office \$40 Co-payment ▪ Medical Services at a participating retail clinic \$15 per visit ▪ Medical Services at a non-participating Urgent/Immediate Care facility or non-participating retail clinic \$60 Co-payment
FAMILY PLANNING	<ul style="list-style-type: none"> ▪ Voluntary family planning services \$15 per visit ▪ Sterilization (In addition to any Outpatient Facility charge) \$250 Co-payment
ALLERGY TREATMENTS	<ul style="list-style-type: none"> ▪ Injections \$10 per visit ▪ Skin testing \$50 per course of testing
AMBULANCE	<ul style="list-style-type: none"> ▪ Ambulance transport for emergency services \$100 Co-payment ▪ Non-emergent ambulance services are covered when the skill of medically trained personnel is required and the Member cannot be safely transported by other means
PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES	<ul style="list-style-type: none"> ▪ Short-term physical, speech or occupational therapy for acute conditions \$15 per visit <p>Coverage is limited to 30 visits per calendar year for all services combined</p>
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER	<ul style="list-style-type: none"> ▪ Applied Behavior Analysis services \$15 per visit ▪ Physical, speech or occupational therapy for the treatment of Autism Spectrum Disorder \$15 per visit <p>Coverage for all services related to Autism Spectrum Disorder is limited to \$36,000 annually and may not exceed \$200,000 in total benefits.</p>
SKILLED NURSING FACILITIES AND REHABILITATION CENTERS	<ul style="list-style-type: none"> ▪ Up to 20 days post-hospitalization care per calendar year when prescribed by physician and authorized by AvMed \$50 per day
CARDIAC REHABILITATION	<p>Cardiac rehabilitation is covered for the following conditions:</p> <ul style="list-style-type: none"> ▪ Acute myocardial infarction \$20 per visit ▪ Percutaneous transluminal coronary angioplasty (PTCA) Benefits limited to \$1,500 per calendar year ▪ Repair or replacement of heart valves ▪ Coronary artery bypass graft (CABG), or ▪ Heart transplant <p>Coverage is limited to 18 visits per calendar year</p>
HOME HEALTH CARE	<ul style="list-style-type: none"> ▪ Limited to 60 skilled visits per calendar year NO CHARGE
DURABLE MEDICAL EQUIPMENT AND ORTHOTIC APPLIANCES	<p>Equipment includes:</p> <ul style="list-style-type: none"> ▪ Hospital beds \$50 per episode of illness ▪ Walkers ▪ Crutches ▪ Wheelchairs <p>Orthotic appliances are limited to:</p> <ul style="list-style-type: none"> ▪ Leg, arm, back and neck custom-made braces Benefits limited to \$500 per calendar year
PROSTHETIC DEVICES	<p>Prosthetic devices are limited to:</p> <ul style="list-style-type: none"> ▪ Artificial limbs ▪ Artificial joints ▪ Ocular prostheses NO CHARGE

FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-88-AVMED (1-800-882-8633)

This Schedule of Benefits is not a contract. For specific information on Benefits, Exclusions and Limitations, please consult your AvMed Group Medical and Hospital Service Contract.

PLEASE NOTE: This benefit plan will be administered in accordance with the requirements of Health Care Reform.

Benefit Summary



POINT-OF-SERVICE BENEFITS	SCHEDULE OF OUT-OF-NETWORK BENEFITS	COST TO MEMBER
DEDUCTIBLE	INDIVIDUAL/FAMILY	\$500/\$1,500 Annually
CO-INSURANCE OUT-OF-POCKET MAXIMUM	INDIVIDUAL/FAMILY	\$3,000/\$6,000 Annually
LIFETIME MAXIMUM	\$2,000,000 PER MEMBER	
PRIOR AUTHORIZATION	Required for specific covered services. The penalty for not obtaining prior authorization is a 20% reduction in benefits.	
PHYSICIAN	<p>Services in physicians' offices include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ Routine office visits/annual well-woman examination ▪ Maternity-outpatient visits ▪ Pediatric care and well-child care ▪ Diagnostic imaging, laboratory or other diagnostic services ▪ Minor surgical procedures ▪ Vision and hearing screenings for children under 18 	30% of the Maximum Allowable Payment, after Deductible
HOSPITAL	<p>Inpatient care at Hospitals includes:</p> <ul style="list-style-type: none"> ▪ Room and board – unlimited days (semi-private) ▪ Physicians', specialists' and surgeons' services ▪ Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication ▪ Intensive care unit and other special units, general and special duty nursing ▪ Laboratory and diagnostic imaging ▪ Required special diets ▪ Radiation and inhalation therapies 	30% of the Maximum Allowable Payment, after Deductible
OUTPATIENT SERVICES	<ul style="list-style-type: none"> ▪ Outpatient surgeries, including cardiac catheterizations and angioplasty ▪ Outpatient therapeutic services, including: <ul style="list-style-type: none"> • Drug infusion therapy • Injectable drugs (Co-payment for Injectable Drug waived if incidental to same-day drug infusion therapy) 	30% of the Maximum Allowable Payment, after Deductible
OUTPATIENT DIAGNOSTIC TESTS	<ul style="list-style-type: none"> ▪ CAT Scan, PET Scan, MRI ▪ Other diagnostic imaging tests 	30% of the Maximum Allowable Payment, after Deductible
ALLERGY TREATMENTS	<ul style="list-style-type: none"> ▪ Injections ▪ Skin testing 	30% of the Maximum Allowable Payment, after Deductible

Benefit Summary, continued

PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES	<ul style="list-style-type: none"> ▪ Short-term physical, speech or occupational therapy for acute conditions <p>Coverage is limited to 30 visits per calendar year for all services combined</p>	30% of the Maximum Allowable Payment, after Deductible
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER	<ul style="list-style-type: none"> ▪ Applied Behavior Analysis services ▪ Physical, speech or occupational therapy for the treatment of Autism Spectrum Disorder <p>Coverage for all services related to Autism Spectrum Disorder is limited to \$36,000 annually and may not exceed \$200,000 in total benefits.</p>	30% of the Maximum Allowable Payment, after Deductible
SKILLED NURSING FACILITIES AND REHABILITATION CENTERS	<ul style="list-style-type: none"> ▪ Up to 20 days per calendar year when prescribed by physician and authorized by AvMed 	30% of the Maximum Allowable Payment, after Deductible
CARDIAC REHABILITATION	<p>Cardiac Rehabilitation is covered for the following conditions:</p> <ul style="list-style-type: none"> ▪ Acute myocardial infarction ▪ Percutaneous transluminal coronary angioplasty (PTCA) ▪ Repair or replacement of heart valves ▪ Coronary artery bypass graft (CABG), or ▪ Heart transplant <p>Coverage is limited to 18 visits per calendar year</p>	\$20 per visit Benefits limited to \$1,500 per calendar year
HOME HEALTH CARE	<ul style="list-style-type: none"> ▪ Limited to 60 skilled visits per calendar year 	30% of the Maximum Allowable Payment, after Deductible
DURABLE MEDICAL EQUIPMENT AND ORTHOTIC APPLIANCES	<p>Equipment includes:</p> <ul style="list-style-type: none"> ▪ Hospital beds ▪ Walkers ▪ Crutches ▪ Wheelchairs <p>Orthotic appliances are limited to:</p> <ul style="list-style-type: none"> ▪ Leg, arm, back and neck custom-made braces 	\$50 per episode of illness Benefits limited to \$500 per calendar year
PROSTHETIC DEVICES	<p>Prosthetic devices are limited to:</p> <ul style="list-style-type: none"> ▪ Artificial limbs ▪ Artificial joints ▪ Ocular prostheses 	30% of the Maximum Allowable Payment, after Deductible

FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-88-AVMED (1-800-882-8633)

This Schedule of Benefits is not a contract. For specific information on Benefits, Exclusions and Limitations, please consult your AvMed Group Medical and Hospital Service Contract and Point-of-Service Amendment.

PLEASE NOTE: This benefit plan will be administered in accordance with the requirements of Health Care Reform.



Open Access Point-of-Service Amendment

AvMed Health Plans Group Medical and Hospital Service Contract is hereby amended and supplemented by the terms and conditions of this amendment.

Nothing contained in this amendment will be held to vary, alter, waive or extend any of the terms, conditions, provisions, Exclusions or Limitations of the HMO Contract to which this amendment is attached, other than as specifically stated herein. Furthermore, when additional benefit riders are selected, those benefits are subject to the Point-of-Service amendment Deductible and Co-insurance arrangements when using Non-participating Providers unless services are specifically excluded herein.

Additionally, this amendment in no way extends benefits beyond what has been stated in this amendment and the Schedule of Point-of-Service Benefits or in the HMO Contract and Schedule of Benefits in terms of specific service limits or benefit maximums. This amendment does not create any duplication of coverage or coordination of benefits contained in the HMO Contract or any other riders the Subscribing Group may elect.

Point-of-Service Benefits

A Member is eligible to receive medical care and services including medical, surgical, diagnostic, therapeutic and preventive services. Coverage is provided for health services that are:

- Received while you are covered under this Group Plan;
- Performed, prescribed or directed by a physician;
- Medically Necessary (except for preventive services as stated herein) for the diagnosis and treatment of injury or illness, as determined by AvMed; and
- Not excluded under Parts XI. and XII. or any other provision, rider or amendment made a part of this Group Plan.

This Point-of-Service (POS) Amendment allows you to receive benefits for covered services and supplies outside the AvMed HMO network. When medical services are needed, you are free to obtain care from your HMO Primary Care Physician (PCP) or you may also consult with the Health Professional of your choice. However, your responsibilities for payment and claim filing will be greater when covered services and supplies are accessed outside the HMO system.

You are free to choose any Health Professional when health care services are needed. By using a Health Professional who has contracted with the AvMed Provider Network (a Participating Provider), the benefit payment level will often be higher than that for services or supplies provided by a Health Professional who has not contracted with the AvMed Provider Network (a Non-participating Provider). See the HMO and POS Schedules for more details on how these options can work best for you.

This Open Access POS amendment eliminates the requirement that each Member choose a PCP as outlined in the HMO Group Medical and Hospital Service Contract. In the event that you do choose a PCP, AvMed must be notified and you must receive approval prior to changing your PCP. Such change will become effective on the first day of the month after you notify AvMed. You cannot change your PCP selection more than once per month. You must continue to have certain HMO network services authorized by AvMed in order to obtain maximum benefits under the HMO coverage. Under the POS amendment, some services will require your Non-participating Provider to request prior authorization as described herein.

Open Access Point-of-Service Amendment, continued

Benefit Payment Levels

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

This POS amendment to the HMO Group Medical and Hospital Service Contract creates two benefit payment levels; one for services provided by AvMed HMO Participating Providers and a second for services provided by Non-participating Providers. The benefit level this Group Plan will pay depends on the Health Professional you select to provide covered health care services:

1. If the Health Professional used is part of the AvMed Participating Provider Network, benefits for covered services are payable at the Participating Provider benefit level shown in the HMO Schedule of Benefits. Although you are entitled to see participating Specialty Health Care Physicians without a referral from a PCP, certain services rendered by a Specialty Health Care Physician require prior authorization, including some services performed in the physician's office. If you receive other covered services through a Participating Provider which require prior authorization or special authorization but have not been authorized by your PCP or AvMed, benefits may not be payable under the HMO Participating Provider benefit. Those services may be payable under the POS Non-participating Provider benefit if the service or supply is covered as specified in this POS amendment and Schedule.
2. If the Health Professional used is not part of AvMed Participating Provider network, benefits for services covered under this POS amendment are payable at the Non-participating Provider benefit level specified in the POS amendment Schedule.

Cost-Sharing Information

Deductible. Before AvMed will begin paying expenses for services covered under this POS amendment, you must satisfy the annual Deductible specified in the POS Schedule. The Deductible means the amount a Member must pay each calendar year for covered services from his or her own pocket before AvMed will make payments for eligible expenses. The individual Deductible or family Deductible must be satisfied each calendar year before any payment will be made by AvMed for any claim.

If two or more covered members of a family incur injury due to the same accident, the Deductible applies only once for all such expenses. If during a calendar year, the covered members of a family incur eligible expenses for which no benefits are payable because of the Deductible requirements and the amount of such eligible expense equals the family Deductible limit, then no further Deductible will apply to the covered members of the family during the remainder of such calendar year.

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

Only those eligible expenses submitted on claims to AvMed Health Plans will be credited toward the Deductible. Expenses that are **not** eligible will not be counted toward the satisfaction of the Deductible. Eligible expenses are only those amounts included in the Maximum Allowable Payment as described below.

Open Access
Point-of-Service Amendment, continued

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

Maximum Allowable Payment means the maximum amount that AvMed will pay for any covered service rendered by a Non-participating Provider or supplier of services, medications or supplies. The maximum amount that AvMed will pay for each such covered service can be found on the Maximum Allowable Payment Schedule at www.avmed.org.

Annual Out-of-Pocket Maximum Limits. Co-insurance and Co-payments you pay for benefits received during any calendar year under this amendment are accumulated toward your annual maximum out-of-pocket. Once you meet your individual or family maximum out-of-pocket limit in any calendar year, the Plan will pay 100% of the Maximum Allowable Payment for all covered services for the remainder of that calendar year.

Expenses that do not count toward the annual out-of-pocket maximum are expenses related to services not covered by this POS amendment, additional amounts incurred for failure to pre-authorize a service requiring prior authorization, expenses that relate to services that exceed any specific treatment limitations noted in the Schedules, expenses used to satisfy the individual or family Deductible and Co-payments paid by you for services provided exclusively under the Group Medical and Hospital Service Contract.

Lifetime Maximum Benefit. While this Group Plan stays in force, the eligible expenses incurred by a Member are limited to the applicable maximum shown in the POS Schedule. When benefits in such amount have been paid or are payable under this amendment, all coverage under this amendment will terminate for the Member.

Effect of Prior Coverage. The following provision applies to Members who, on the day before this Group Plan effective date, were covered under prior coverage. Prior coverage means the policyholder’s group medical plan that this Group Plan replaced. AvMed will automatically cover any such person under this Group Plan on its effective date, subject to the following provision.

Those persons eligible according to the terms of this Group Plan will be covered at the level of benefits of this Group Plan. This includes persons who were covered under a continuation provision of the prior coverage to the extent it was required by state or federal law. This continued coverage under this Group Plan will terminate on the date that coverage would have terminated according to the law under the prior coverage, had the prior coverage remained in force.

The Deductible Credit Provision. Any expenses incurred by a Member while covered under the prior coverage will be credited toward satisfaction of the Deductible under this Plan if:

- The expenses were incurred during the 90-day period before the effective date of the Group Plan;
- The expenses were applied toward satisfaction of the Deductible under the prior coverage during the 90-day period before the effective date of this Group Plan; and
- The expenses would be considered eligible expenses under this Group Plan.

However, in order to receive credit, you must supply evidence of satisfaction of the Deductible under the prior coverage by providing AvMed written proof of what has been paid by prior coverage.

The Carryover Provision: if any part or all of the Deductible has been satisfied during the last 3 months of the preceding calendar year, the Deductible for the next calendar year will be reduced by the amount satisfied.

Open Access

Point-of-Service Amendment, continued

Prior Authorization of Covered Services

In order to determine whether services and supplies are Medically Necessary, certain covered services require prior authorization from AvMed Health Plans. Prior authorization ensures a Member of receiving the most appropriate medical care available, in the most appropriate setting. If your physician is a Participating Provider, then he or she will handle all authorizations, notifications and utilization reviews with AvMed.

If your doctor is not a Participating Provider, you are responsible for making sure your physician or Health Professional calls AvMed to obtain prior authorization for a covered service when it is required. Please refer to your Member ID card for the telephone number where authorization may be obtained, or have your physician call 1-800-443-4103.

Before the service is performed, you should verify with your provider that the service has received prior authorization. If you are unable to secure verification from your provider, you may also call AvMed. Please remember that failure to receive prior authorization of a service will result in a reduction in coverage. The amount of the reduction can be found in the POS Schedule.

The following services require prior authorization:

- Inpatient admissions (Hospital and observation stays, skilled nursing facilities, ventilator dependent care and/or acute rehabilitation).
- Inpatient and outpatient surgery, including cardiac catheterization and percutaneous transluminal coronary angioplasty (PTCA).
- PET Scans.

It is important to remember that benefits for Hospital admissions not authorized in advance will be reduced by the amount shown in the POS Schedule. This reduction will occur regardless of whether such confinements are deemed Medically Necessary. If hospitalization is extended without authorization beyond the number of days approved, benefits for the extra days will be similarly reduced.

Exclusions and Limitations

The benefit Exclusions and Limitations specified in the HMO Group Medical and Hospital Service Contract are also applicable to the benefits specified in this POS amendment. Additionally, services not covered under this POS amendment include:

- Services provided exclusively under the HMO Group Medical and Hospital Service Contract.
- Second medical opinions are covered exclusively through the HMO portion of the benefits and are not available as point-of-service benefits.
- Transplantation services must be authorized by AvMed and provided exclusively through the HMO network. However, any follow-up care managed by a Participating Provider outside of the AvMed Service Area will be subject to the out-of-network benefit and reimbursement.
- Any applicable prescription benefits are available only under the HMO portion of coverage. They are not available as out-of-network benefits.
- Hospice services.
- Dialysis care.
- Ambulance services.
- Voluntary family planning services, sterilization, infertility evaluation and medical treatment, surgery for the enhancement of fertility and genetic counseling.

Open Access

Point-of-Service Amendment, continued

- Emergency Medical Services and Care for an Emergency Medical Condition. Emergency services **administered by any provider will be covered under the HMO Contract benefits.** In order for the care to be covered under the HMO, AvMed must be notified as described in Section 10.12 of the HMO Group Medical and Hospital Service Contract. If notification is not provided as specified under the HMO contract, services may be payable under the POS amendment if the service or supply received is a covered service as specified in this POS amendment and Schedule.
- Durable medical equipment, orthotic appliances and prosthetic devices are limited to those items specified in the POS Schedule. In addition, custom wheelchairs, electric wheelchairs and scooters must be authorized by AvMed and provided by the HMO network.

Payment of Claims

When you receive services from a Non-participating Provider, the provider must bill AvMed directly for the services rendered, and you will pay the physician directly all or part of the annual Deductible if not satisfied, and the required percentage of Co-insurance. You must also comply with the following claim filing procedures when receiving covered services from Non-participating Providers.

Notice of Claim. Notice of a claim for benefits must be given to AvMed. The notice must be in writing, and any claim will be based on that written notice. The notice must be received by AvMed within six months after the start of the loss on which the claim is based. If notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the six month period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

When written notice is required under this Plan, it shall be mailed to:

AvMed Health Plans
P. O. Box 560844
Miami, Florida 33156

You should call 1-800-882-8633 if assistance is needed regarding a claim or information about coverage.

Proof of Loss. Written proof of loss must be given to AvMed within six months after the date of injury or sickness for which claim is made. If it was not reasonably possible to give written proof in the time required, AvMed will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible.

Legal Actions. No legal action may be brought to recover under this amendment until at least 60 days after written proof of claim has been filed with AvMed. If such action is taken after the 60-day period, it must be taken prior to the expiration of the statute of limitations from the date written proof of claim was required to be filed.

Overview – Member Responsibilities When Receiving Covered Services

*Open Access
Point-of-Service Amendment, continued*

Responsibilities when using Participating Providers. All paperwork is handled by Participating Providers, so there are no bills for you to submit to AvMed. However, it is your responsibility to:

1. Verify the participation status of (a) the Health Professional who prescribes the treatment, and (b) the Health Professional who provides the covered service.
2. Pay the applicable Co-payment or Co-insurance at the time of service.

Responsibilities when using Non-participating Providers:

1. Know which covered services require prior authorization and comply with all requirements specified in this amendment.
2. Pay eligible expenses applied toward satisfaction of the Deductible. The Deductible must be satisfied before benefits begin.
3. Pay the Co-insurance amount required.
4. Pay any amount of eligible expense which exceeds the Maximum Allowable Payment.
5. Pay any increase in Co-insurance if prior authorization requirements are not followed as stated in this amendment.
6. Pay any amounts requested for services and supplies not covered under this amendment.
7. You must complete and submit claim forms and provider bills to AvMed.

Amendment



Open Access to Specialty Healthcare Physicians

As of the Effective Date, the introductory language of section **X. Schedule of Basic Benefits** of the Group Medical and Hospital Service Contract is amended as follows:

Each Member may select one Primary Care Physician (PCP) upon enrollment, but is not required to do so. In the event that you do choose a PCP, the Health Plan must be notified and you must receive approval prior to changing your PCP. Such change will become effective on the first day of the month after you notify Health Plan. You cannot change your PCP selection more than once per month.

You are entitled to see participating Specialty Health Care Physicians without a referral from your PCP. Self-referral is not permitted to participating Specialty Health Care Physicians designated as "Requires Special Consultation between your Doctor and the AvMed Medical Director" in the written or electronic Provider Directories at the time of service.

Health Professionals may from time to time cease their affiliation with Health Plan. In such cases, you will be required to receive services from another Participating Health Professional.

Prescription Medication Benefits



\$10/20/30/75/50% CO-PAYMENT with Contraceptives

DEFINITIONS

Brand medication means a Prescription Drug that is usually manufactured and sold under a name or trademark by a pharmaceutical manufacturer or a medication that is identified as a Brand medication by AvMed. AvMed delegates determination of Generic/Brand status to our Pharmacy Benefits Manager.

Brand Additional Charge means the additional charge that must be paid if you choose a Brand medication when a Generic equivalent is available. The charge is the difference between the cost of the Brand medication and the Generic medication. This charge must be paid in addition to the applicable Non-Preferred Brand Co-payment. However, if the prescribing physician or other Participating Provider authorized to prescribe medications within the scope of his or her license indicates on the prescription Brand medically necessary or dispense as written for a medication for which there is a generic equivalent, the Brand medication shall be dispensed for the applicable Non-Preferred Brand Co-payment only.

Cost-sharing Medications are those medications, as designated by AvMed, which were designed to improve the quality of life by treating relatively minor non-life threatening conditions or which have multiple generic or non-prescription therapeutic alternatives. Such medications are subject to Co-insurance and coverage is limited as outlined below.

Dental-specific Medication is medication used for dental-specific purposes, including but not limited to fluoride medications and medications packaged and labeled for dental-specific purposes.

Formulary List means the listing of preferred and non-preferred medications as determined by AvMed's Pharmacy and Therapeutics Committee based on clinical efficacy, relative safety and cost in comparison to similar medications within a therapeutic class. This multi-tiered list establishes different levels of Co-payment for medications within therapeutic classes. As new medications become available, they may be considered excluded until they have been reviewed by AvMed's Pharmacy and Therapeutics Committee.

Generic medication means a medication that has the same active ingredient as a Brand medication or is identified as a Generic medication by AvMed's Pharmacy Benefits Manager.

Injectable Medication is a medication that has been approved by the Food and Drug Administration (FDA) for administration by one or more of the following routes: intramuscular injection, intravenous injection, intravenous infusion, subcutaneous injection, intrathecal injection, intrarticular injection, intracavernous injection or intraocular injection. Prior authorization is required for all Injectable Medications.

Maintenance Medication is a medication that has been approved by the FDA, for which the duration of therapy can reasonably be expected to exceed one year.

Participating Pharmacy means a pharmacy (retail, mail order or specialty pharmacy) that has entered into an agreement with AvMed to provide Prescription Drugs to AvMed Members and has been designated by AvMed as a Participating Pharmacy.

Prescription Drug means a medication that has been approved by the FDA and that can only be dispensed pursuant to a prescription according to state and federal law.

Prior Authorization means the process of obtaining approval for certain Prescription Drugs (prior to dispensing) according to AvMed's guidelines. The prescribing physician must obtain approval from AvMed. The list of Prescription Drugs requiring Prior Authorization is subject to periodic review and modification by AvMed. A copy of the list of medications requiring Prior Authorization and the applicable criteria are available from Member Services or from the AvMed website.

HOW DOES YOUR RETAIL PRESCRIPTION COVERAGE WORK?

To obtain your Prescription Drug, take your prescription to, or have your physician call, an AvMed Participating Pharmacy. Your physician should submit prescriptions for Injectable Medications to AvMed's specialty pharmacy. Present your prescription along with your AvMed identification card. Pay the following Co-payment (as well as the Brand Additional Charge if you choose a Brand product when a Generic equivalent is available).

Tier 1	Preferred Generic Medications:	\$ 10.00	Co-payment
Tier 2	Preferred Brand Medications:	\$ 20.00	Co-payment
Tier 3	Non-Preferred Brand or Generic Medications:	\$ 30.00	Co-payment
Tier 4	Injectable Medications:	\$ 75.00	Co-payment
Tier 5	Cost-sharing Medications:	50%	Co-Insurance

ORDERING YOUR PRESCRIPTIONS THROUGH THE MAIL

Mail service is a benefit option for maintenance medications needed for chronic or long-term health conditions. It is best to get an initial prescription filled at your retail pharmacy. Ask your physician for an additional prescription for up to a 90 day supply of your medication to be ordered through mail service. Up to 3 refills are allowed per prescription. Pay the following Co-payment (as well as the Brand Additional Charge if you choose a Brand product when a Generic equivalent is available).

Tier 1	Preferred Generic Medications:	\$ 20.00	Co-payment
Tier 2	Preferred Brand Medications:	\$ 40.00	Co-payment
Tier 3	Non-Preferred Brand or Generic Medications:	\$ 60.00	Co-payment
Tier 4	Injectable Medications are not available through mail service		
Tier 5	Cost-sharing Medications are not available through mail service		

Prescription Medication Benefits, continued

WHAT IS COVERED?

- Your Prescription Drug coverage includes outpatient medications (including contraceptives) that require a prescription and are prescribed by your AvMed physician in accordance with AvMed's coverage criteria. AvMed reserves the right to make changes in coverage criteria for covered products and services. Coverage criteria are medical and pharmaceutical protocols used to determine payment of products and services and are based on independent clinical practice guidelines and standards of care established by government agencies and medical/pharmaceutical societies.
- Your Prescription Drug coverage may require Prior Authorization, including the Progressive Medication Program, for certain covered medications. The Progressive Medication Program encourages the use of therapeutically-equivalent lower-cost medications by requiring certain medications to be utilized to treat a medical condition prior to approving another medication for that condition. This includes the first-line use of preferred medications that are proven to be safe and effective for a given condition and can provide the same health benefit as more expensive non-preferred medications at a lower cost.
- Your retail Prescription Drug coverage includes up to a 30-day supply of a medication for the listed Co-payment. Your prescription may be refilled via retail or mail order after 75% of your previous fill has been used and subject to a maximum of 13 refills per year. You also have the opportunity to obtain a 90-day supply of medications used for chronic conditions including, but not limited to asthma, cardiovascular disease, and diabetes from the retail pharmacy for the applicable Co-payment per 30-day supply. However, Prior Authorization may be required for covered medications.
- Your mail-order Prescription Drug coverage includes up to a 90-day supply of a routine maintenance medication for the listed Co-payment. If the amount of medication is less than a 90-day supply, you will still be charged the listed mail order Co-payment.
- Your Injectable Medication coverage extends to many injectable medications approved by the FDA. These medications must be prescribed by a physician and dispensed by a retail or specialty pharmacy. The Co-payment levels for Injectable Medications apply regardless of provider. This means that you are responsible for the appropriate Co-payment whether you receive your Injectable Medication from the pharmacy, at the physician's office or during home health visits. Injectable Medications are limited to a 30-day supply.
- Your Prescription Drug coverage includes coverage for injectable contraceptives. There is a Co-payment of \$30 for each injection. If there is an office visit associated with the injection, there will be an additional Co-payment required for the office visit.
- Quantity limits are set in accordance with FDA approved prescribing limitations, general practice guidelines supported by medical specialty organizations, and/or evidence-based, statistically valid clinical studies without published conflicting data. This means that a medication-specific quantity limit may apply for medications that have an increased potential for over-utilization or an increased potential for a Member to experience an adverse effect at higher doses.

QUESTIONS? Call your AvMed Member Services Department at: 1-800-88-AvMed (1-800-882-8633)

EXCLUSIONS AND LIMITATIONS

- Medications which do not require a prescription (i.e. over-the-counter medications) or when a non-prescription alternative is available, unless otherwise indicated on AvMed's Formulary List.
- Medications not included on AvMed's Formulary List.
- Medical supplies, including therapeutic devices, dressings, appliances and support garments
- Replacement Prescription Drug products resulting from a lost, stolen, expired, broken or destroyed prescription order or refill
- Diaphragms and other contraceptive devices
- Fertility drugs
- Medications or devices for the diagnosis or treatment of sexual dysfunction
- Dental-specific Medications for dental purposes, including fluoride medications
- Prescription and non-prescription vitamins and minerals except prenatal vitamins
- Nutritional supplements
- Immunizations
- Allergy serums, medications administered by the Attending Physician to treat the acute phase of an illness and chemotherapy for cancer patients are covered in accordance with the Group Medical and Hospital Service Contract and may be subject to Co-payments or Co-insurance as outlined on the Schedule of Benefits
- Investigational and experimental drugs (except as required by Florida statute)
- Cosmetic products, including, but not limited to, hair growth, skin bleaching, sun damage and anti-wrinkle medications
- Nicotine suppressants and smoking cessation products and services
- Prescription and non-prescription appetite suppressants and products for the purpose of weight loss
- Compounded prescriptions, except pediatric preparations
- Medications and immunizations for non-business related travel, including Transdermal Scopolamine

Filling a prescription at a pharmacy is not a claim for benefits and is not subject to the Claims and Appeals procedures under ERISA. However, any medicines that require Prior authorization will be treated as a claim for benefits subject to the Claims and Appeals Procedures, as outlined in the Group Medical and Hospital Service Contract.



Addendum

Coverage for Mammograms – Waiver of Co-payment

If selected, the following provision is hereby modified for an additional premium:

Section 10.28 of the AvMed Health Plans Group Medical and Hospital Service Contract is amended to state:

Mammograms are covered in accordance with *Florida Statutes*: one baseline mammogram is covered for female Members between the ages of 35 and 39; a mammogram is available every two years for female Members between the ages of 40 and 49; and a mammogram is available every year for female Members aged 50 and older.

In addition, one or more mammograms a year are available when based upon a physician's recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of 30. **This coverage will not be subject to diagnostic imaging Co-payments.**



Amendment

Durable Medical Equipment

If selected, the following coverage is hereby modified, for an additional premium.

DURABLE MEDICAL EQUIPMENT

- Benefits are limited to a maximum of \$2,000 per contract year*.

All other coverage provisions, including co-payment, limitations and exclusions remain as stated in the Certificate of Coverage or Schedule of Co-Payments.

*For the treatment of diabetes, coverage for an infusion pump will not apply toward the annual maximum limitation and shall not be subject to the durable medical equipment benefit limitation.



Amendment

ELECTIVE TERMINATION OF PREGNANCY

If selected, the following optional coverage is hereby added:

The AvMed Health Plan Group Medical and Hospital Service Contract is amended to state:

- Elective termination of pregnancy will be a covered benefit if the services and treatment are provided by an AvMed participating provider in an AvMed participating facility. There shall be a physician copayment of \$100.00 in addition to the applicable facility copayment.

Amendment



Mental Health Services

As of the effective date, outpatient and inpatient mental health services are covered, when Medically Necessary, subject to the following Member cost sharing responsibility:

- Outpatient mental health services are covered subject to the Member's applicable cost sharing responsibility for specialist services.
- Inpatient or partial hospitalization for mental health services is covered when a Member is admitted to a Hospital or Health Care Facility. Coverage is subject to the Member's applicable cost sharing responsibility for inpatient Hospital Services.

Prior authorization is required for mental health services. Please consult the Schedule of Benefits for Member cost sharing responsibility and Deductible information, if applicable. For further information, contact AvMed at 1-800-882-8633.

Amendment



Substance Abuse Services

As of the effective date, outpatient and inpatient substance abuse services are covered, when Medically Necessary, subject to the following Member cost sharing responsibility:

- Outpatient substance abuse services are covered subject to the Member's applicable cost sharing responsibility for specialist services.
- Inpatient or partial hospitalization for substance abuse services is covered when a Member is admitted to a Hospital or Health Care Facility. Coverage is subject to the Member's applicable cost sharing responsibility for inpatient Hospital Services.

Prior authorization is required for substance abuse services. Please consult the Schedule of Benefits for Member cost sharing responsibility and Deductible information, if applicable. For further information, contact AvMed at 1-800-882-8633.