CITY CLERK
CITY OF SUNRISE

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CERTIFICATION
I certify this to be a true and correct copy of the original document on file at Sunrise City Hall.

Witness my hand and official seal of the City of Sunrise, Florida this 23rd day of September, 2014.

Felicia M. Bravo, Sunrise City Clerk

SUNRISE, FLORIDA

RESOLUTION NO. 14-107

A RESOLUTION OF THE CITY OF SUNRISE, FLORIDA, AWARDING THIRD-PARTY ADMINISTRIVE SERVICES ONLY FOR SELF-FUNDED HMO AND NPOS OPEN ACCESS EMPLOYEE GROUP HEALTH INSURANCE PLANS, INCLUDING PHARMACY BENEFIT MANAGEMENT TO AVMED, INC.; AND PROVIDING FOR AN EFFECTIVE DATE.

WHEREAS, the City, through its benefits consultant, The Rhodes Insurance Group, Inc. (Consultant), issued a Request for Proposal (RFP) for Third-Party Administrative Services Only for Self-Funded HMO and NPOS Open Access Employee Group Health Insurance Plans, Including Pharmacy Benefit Management; and

WHEREAS, the RFP's Evaluation Committee (Committee) performed a carrier medical and pharmacy network discount actuarial cost analysis, network disruption analysis, plan provisions compliance analysis, analysis of responses to RFP's questionnaire, review of client satisfaction based on references, ability to provide the requested reports, and analysis total expected costs of selected services proposed on all proposals received based on Third-Party Administrative Services Only for Self-Funded HMO and NPOS Open Access Employee Group Health Insurance Plans,

Including Pharmacy Benefit Management and short-listed Humana, AvMed, Inc., Aetna and Cigna; and

WHEREAS, based on the Consultant's and Committee's evaluation, and after best and final negotiations with Humana and AvMed, Inc., staff is recommending AvMed, Inc. to administer the Third-Party Administrative Services Only for Self-Funded HMO and NPOS Open Access Employee Group Health Insurance Plans, Including Pharmacy Benefit Management;

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COMMISSION OF THE CITY OF SUNRISE, FLORIDA:

Section 1. The Request for Proposal for Third-Party Administrative Services Only for Self-Funded HMO and NPOS Open Access Employee Group Health Insurance Plans, Including Pharmacy Benefit Management is awarded to AvMed, Inc.

Section 2. The Risk Manager is hereby authorized to negotiate and execute an Agreement with AvMed, Inc. subject to City Manager and City Attorney approval. The Risk Manager is further authorized to execute any necessary insurance applications, self-fund plan documents, performance guarantee agreements, business associate agreements, forms, binders, amendments, extensions or other

related documents necessary to effectuate the self-funded medical insurance plans, subject to City Attorney approval.

Section 3. Effective Date. This Resolution shall be effective immediately upon its passage.

PASSED AND ADOPTED THIS 12TH DAY OF AUGUST, 2014.

Mayor Michael J. Ryan

Authentication:

Felicia M. Bravo
City Clerk

MOTION:	SCUOTTO
SECOND:	ROSEN
KERCH:	YEA
ROSEN:	YEA
SCUOTTO:	YEA
SOFIELD:	YEA
RYAN:	YEA

Approved by the City Attorney
as to Form and Legal Sufficiency. Kimberly A. Kisslan

Administrative Services Agreement

Relative to the

Exclusive Provider Network (HMO) and Point of Service (POS) Benefit Plans

Between

AvMed, Inc. d/b/a AvMed

and

City of Sunrise, a municipal corporation

Effective January 1, 2015

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ADMINISTRATIVE SERVICES AGREEMENT

This Agreement, made effective this 1st day of January, 2015, by and between City of Sunrise, a municipal corporation (Employer), and AvMed, Inc., a Florida corporation (AvMed).

WITNESSETH:

WHEREAS, the Employer, in its role as plan sponsor, has adopted and self-funds the program of employee group health benefits described in the Exclusive Provider Network (HMO) Summary Plan Document and Point of Service (POS) Summary Plan Document, collectively, see EXHIBIT A (the 'Plan') for the benefit of its Subscribers and Participants; and

WHEREAS, the Employer has requested AvMed to furnish certain administrative services to the Plan, including (1) receiving and processing claims for benefits under the Plan, (2) disbursing claim payments under the Plan, and (3) performing the Plan-related administrative duties specified in EXHIBIT B, Basic Administrative Services and Charges; and

WHEREAS, except as otherwise specifically provided herein, the Employer is to retain all liabilities under the Plan and AvMed is to provide the agreed upon services to the Plan without assuming any such liability under the Plan.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, it is hereby agreed as follows:

I. DEFINITIONS

As used in this Agreement, each of the following terms will have the meaning indicated:

1.01 **Agreement** means this Administrative Services Agreement between the Employer and AvMed and all amendments, addenda, exhibits, supplemental agreements, and schedules which are or may be incorporated in this Agreement from time to time.

1.02 **AvMed, Inc., or AvMed**, means a private, not-for-profit Florida corporation, state licensed as a health maintenance organization and a third party administrator under Chapters 641 and 626, *Florida Statutes*, which has contracted with the Employer to provide or arrange group medical plan for health care services to Plan Participants under the terms and conditions set forth in this Agreement.

1.03 **Company** means City of Sunrise, a municipal corporation, located at 10770 West Oakland Park Boulevard Sunrise, FL 33351 with FEIN 59-0944587. The Company may also be referred to herein as the '**Plan Sponsor**' or '**Employer**'.

1.04 **Contract Years** means the period of thirty-six (36) consecutive months commencing on the effective date of this Agreement, and otherwise referred to as Year 1 through Year 3 in EXHIBIT B, Part II, A. Basic Administrative Services.

1.05 **Co-payment** means the charge which the Participant is required to pay at the time certain health services are provided under the Plan. The Participant is responsible for the payment of any Copayment charges directly to the provider of the health services at the time of service.

1.06 **Covered COBRA** means any individual continuing coverage under the Plan in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time (COBRA); who meets all applicable eligibility requirements of the Plan as well as federal or state law for Covered COBRA status and is enrolled under the Plan and for whom the administrative service fee required by Section III. has been received by AvMed.

1.07 **Covered Dependent** means any member of a Covered Employee's family who meets all applicable eligibility requirements of the Plan as well as federal or state law for Covered Dependent status, who

is enrolled under the Plan and for whom the administrative service fee required by Section III. has been received by AvMed.

1.08 **Covered Retiree** means any retiree from the Employer based on Employer's Plan, ordinance(s), custom or practice, collective bargaining agreement(s), or pension plan(s), who meets all applicable eligibility requirements of the Plan as well as federal or state law for Covered Retiree status, who is enrolled under the Plan and for whom the administrative service fee required by Section III. has been received by AvMed.

1.09 **Covered Sponsored Dependent** means any individual under Florida Dependent Age Coverage pursuant to Florida Statutes § 627.6562, including legislative amendments thereto, who meets all applicable eligibility requirements of the Plan as well as federal or state law requirement for Covered Sponsored Dependent status, who is enrolled under the Plan and for whom the administrative service fee required by Section III. has been received by AvMed.

1.10 **Covered Employee** means an employee of the Employer, who meets all applicable eligibility requirements of the Plan as well as federal or state law requirement, who enrolls in the Plan and for whom the administrative service fee required by Section III. has been received by AvMed.

1.11 **Extended Contract Years** mean Year 4 and Year 5 in EXHIBIT B, Part II, A. Basic Administrative Services.

1.12 **Multi Plan, Inc.** means various networks, including the PHCS Healthy Directions Network, to serve as wrap-around networks for medical care under Employer's Plan provided outside of the AvMed Service Area when Participants who reside in the AvMed Service Area travel for covered medical services, or reside outside the AvMed Service Area on a permanent or temporary basis.

1.13 **Participant** or **Member** means any Covered Employee, Covered Dependent, Covered Retiree, Covered Sponsored Dependent, or Covered COBRA, who meets all applicable eligibility requirements of the Plan as well as federal or state law for Participant status, who is enrolled under the Plan and for whom the administrative service fee required by Section III. has been received by AvMed.

1.14 **Plan** means Employer's employee group medical plan, as described in the Exclusive Provider Network (HMO) Summary Plan Document and Point of Service (POS) Summary Plan Document, collectively, see EXHIBIT A, maintained by the Employer for the benefit of Employer's Participants, as may be updated from time to time, provided proper notice is given to AvMed pursuant to subsection 12.02 below.

1.15 **Plan Administrator** means City of Sunrise, 10770 West Oakland Park Boulevard, 3rd Floor, Sunrise, FL 33351, Office (954) 572-2496 or Fax # (954) 572-2382. Attention to: Risk Manager, or designee.

1.16 **Service Area** means those counties in the State of Florida where AvMed has been approved to conduct business by the Florida Department of Financial Services, as listed in the Exclusive Provider Network (HMO) Summary Plan Document and Point of Service (POS) Summary Plan Document (SPD) for the Plan, see EXHIBIT A.

1.17 **Subscriber** means any Covered Employee, Covered Retiree, Covered Sponsored Dependent, or Covered COBRA, who meets all applicable eligibility requirements of the Plan as well as federal or state law for Subscriber status, who is enrolled under the Plan and for whom the administrative service fee required by Section III. has been received by AvMed.

II. ELIGIBILITY AND ENROLLMENT

2.01 Employer will:

2.01.01 respond to all routine inquiries from Participants concerning enrollment in the Plan and its terms, conditions, and operations; and

2.01.02 handle all enrollment activity using enrollment forms approved by AvMed, as amended from time to time by AvMed; and

2.01.03 notify Participants of their right to apply for benefits and supply them with claim filing instructions, if required.

2.02 In determining any Participant's right to benefits under the Plan, AvMed will rely upon eligibility information furnished by the Employer. It is mutually understood that the effective performance of this Agreement by AvMed will require that it be advised on a timely basis by the Employer during the continuance of this Agreement of the identity of Participants eligible for benefits under the Plan. Such information will identify the effective date of eligibility and the termination date of eligibility and will be provided promptly to AvMed in a form and with such other information as reasonably may be required by AvMed for the proper administration of claims for benefits under the Plan. Employer represents and warrants that its eligibility determinations will be in accordance with the terms of the Plan.

2.03 Employer acknowledges that its prompt furnishing of complete and accurate eligibility and benefit information is essential to the timely and efficient administration by AvMed of claims for benefits under the Plan. If Employer, or any party designated by Employer, fails to provide AvMed with accurate eligibility information, benefit design requirements, or other agreed-upon data, including but not limited to electronic data, tapes, or software, in an accessible and readable format, and in the time frame and format prescribed by AvMed, AvMed will have no liability whatsoever under this Agreement for any act or omission by AvMed, or its employees, affiliates, subcontractors, agents, or representatives, which is directly or indirectly caused by such failure.

2.04 Employer will notify AvMed of the termination of eligibility of any Participant within thirty (30) days of the date of the loss of eligibility. Employer will remain responsible for all fees, charges, and claims with respect to such terminated individual incurred or charged until ten (10) days following confirmation by AvMed of the receipt of such notification from Employer. All authorizations provided prior to such notice of termination will be honored and will remain the responsibility of the Employer if AvMed is unable to recover funds on behalf of Employer in accordance with Chapter 218, Part VII of the Florida Statutes, to the extent applicable, or any other applicable law. Should AvMed be unable to recover funds on behalf of the Employer, the Employer has the right to recover funds from a Participant for any payment made on behalf of the Participant, and, except as otherwise provided for in Exhibit C, AvMed will not continue to pursue Participant to recover funds but will use best efforts to reasonably cooperate with Employer.

2.05 The eligibility requirements set forth in the Plan will at all times control and no coverage contrary thereto will be effective. Coverage will not be implied due to clerical or administrative errors if such coverage would be contrary to the terms of the Plan.

III. ADMINISTRATIVE FEES

3.01 On or before the first day of each month for which coverage is sought, Employer or its designated agent will remit to AvMed, on behalf of each Subscriber, the monthly charges set forth in EXHIBIT B, Part II, A. Basic Administrative Services. Only Subscribers for whom the stipulated payment is actually received by AvMed will be entitled to the health services covered under this Agreement and then only for the period for which such payment is applicable. Failure of the Employer to pay fees and charges under this Agreement by the first of the month and not later than the end of the grace

period (as provided in Section 3.02) will result in retroactive termination of the Agreement, effective at 12:00 a.m. (midnight) on the last day of the month for which such amounts were paid, unless the payment of amounts due has otherwise been contractually adjusted and specified by the Employer and AvMed in a fully executed addendum to this Agreement. AvMed reserves the right to charge a late fee not to exceed one percent (1%) of the unpaid balance on all payments not received by due date. Employer will be responsible for payment of any assessment of tax or deficiency issued by a state or other jurisdiction that is assessed for services provided pursuant to this Agreement by AvMed to Employer. Notwithstanding the foregoing, Employer will not be responsible for any tax or assessment that AvMed would otherwise incur pursuant to its business functions unrelated to its business relationship with Employer under this Agreement, including:

3.01.01 any real or property related taxes;

3.01.02 any franchise and privilege taxes on Employer's business;

3.01.03 any taxes based on the gross or net income received by Employer; and

3.01.04 any taxes based on the licensing of AvMed, its affiliates or subsidiaries as a third party administrator.

3.02 Grace Period. This Agreement has a thirty (30) day grace period. This provision means that if any required fees and charges are not paid on or before the date they are due, they must be paid during the 30-day grace period. During the grace period, the Agreement will stay in force. However, if payment is not received by the last day of the grace period, termination of this Agreement for nonpayment of fees will be retroactive to 12:00 a.m. (midnight) on the last day of the month for which fees were paid. Note: Certain provisions in Section 4.01 may apply if the Employer and AvMed have executed an addendum affecting charges.

3.03 Refund of fees paid to AvMed by the Employer for any Participant after the date on which that Participant's eligibility ceased or the Participant was terminated will be limited to the total excess fees paid up to a maximum of sixty (60) days from the date of such ineligibility or termination, provided there are no claims incurred subsequent to the effective date of termination. AvMed will not be liable for any preauthorization of services or supplies or claims paid on behalf of individuals who are retroactively determined to be ineligible for benefits under the Plan, if at the time of such preauthorization or payment, AvMed had reason to believe that such individual was eligible to participate in the Plan. No retroactive terminations of Participants will be made beyond sixty (60) days from notification of the terminating event.

3.04 In the event of the retroactive termination of an individual Participant, AvMed will not be responsible for expenses incurred by AvMed in providing benefits to the Participant under the terms of this Agreement after the effective date of termination (due to the Employer's nonpayment of fees or failure to timely notify AvMed of Participant's ineligibility). See EXHIBIT C for payment recovery options.

IV. TERMINATION

All rights and benefits under this Agreement will cease as of the effective date of termination, unless otherwise provided herein.

4.01 This Agreement will continue in effect for the term of the Contract Years from the effective date hereof and may be renewed for the Extended Contract Years , subject to the following termination provisions. All rights to benefits under this Agreement will cease at 12:00 a.m. (midnight) on the effective date of termination.

4.02 **Reasons for Termination**:

4.02.01 **Loss of Eligibility**. Upon loss of a Participant's eligibility as defined under the Plan, coverage under the Plan will automatically terminate during the Contract Years or

Extended Contract Years on the last day of the month for which the monthly administrative fee was paid on behalf of, and during which the Participant was eligible for coverage.

a. Coverage for all Covered Dependents and Covered Sponsored Dependents will automatically terminate during the Contract Years or Extended Contract Years on the last day of the month for which the monthly administrative fee was paid, and during which the Covered Dependents and Covered Sponsored Dependents were eligible for coverage, upon a loss of the Covered Employee's eligibility, as defined under the Plan.

4.02.02 **Failure to Pay Fees**. Upon failure of the Employer to pay any fees under the Agreement within thirty (30) days following the due date specified herein, benefits hereunder will terminate, during the Contract Years or Extended Contract Years,for all Participants for whom such payment has not been received, at 12:00 a.m. (midnight), on the last day of the month for which the monthly fees were paid. AvMed may retroactively cancel the Agreement to the last day of the period for which fees have been paid.

4.02.03 **Termination of Agreement by Plan Sponsor/Employer**. Employer may terminate this Agreement without cause on the anniversary date by providing written notice, pursuant to the notice requirements in Section 14.09, to AvMed no less than sixty (60) days prior to the anniversary date of the Contract Years or Extended Contract Years. In such event, benefits hereunder will terminate for all Participants at 12:00 a.m. (midnight) on the Agreement expiration date. Additionally, Employer may terminate during the Contract Years or Extended Contract Years, or choose not to renew this Agreement based on one or more of the following conditions. In such event, benefits hereunder will terminate for all Participants at 12:00 a.m. (midnight) on the Agreement expiration date as described below.

a. AvMed has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Agreement. This will result in immediate termination of the Agreement;

b. AvMed is in material breach of this Agreement, and does not correct the breach within thirty (30) calendar days after being notified in writing by the Employer. Termination of Agreement will be effective on the last day of such thirty (30) day period.

4.02.04 **Termination of Agreement by AvMed**. AvMed may terminate this Agreement without cause on the anniversary date of the Contract Years or Extended Contract Years, by providing written notice, pursuant to the notice requirements in Section 14.09, to Employer no less than sixty (60) days prior to the anniversary date. In such event, benefits hereunder will terminate for all Participants at 12:00 a.am (midnight) on the Agreement expiration date. AvMed may terminate this Agreement during the Contract Years or Extended Contract Years, or choose not to renew this Agreement based on one or more of the following conditions. In such event, benefits hereunder will terminate for all Participants at 12:00 a.m. (midnight) on the Agreement expiration date as described below.

a. Employer has failed to pay fees or contributions in accordance with the terms of this Agreement or AvMed has not received timely payments (See Section III. Administrative Fees and Section 4.02.02). Termination of coverage will be effective on the last day of the month for which payments were received by AvMed;

b. Employer has failed to provide funds in accordance with Section VII., Funding And Payment Of Claims;

c. Employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Agreement. This will result in immediate termination of the Agreement;

d. There are no longer any Participants covered by the Plan who live, reside, or work in the Service Area. Termination of coverage will be effective on the last day of the month for which payments were received by AvMed;

e. AvMed ceases to provide services in the applicable market. Termination will be effective upon no less than one-hundred and eighty (180) days written notice from AvMed to Plan Sponsor/Employer, pursuant to the notice requirements in Section 14.09;

f. The Employer voluntarily or involuntary files for any chapter under the United States bankruptcy codes.

4.03 **Notification Requirements**:

4.03.01 **Loss of Eligibility of Participant**. It is the responsibility of Employer to notify AvMed in writing within thirty (30) days from the effective date of termination regarding any Participant who becomes ineligible to participate in the Plan. Failure of the Employer to provide timely written notice as described above may lead to retroactive termination of the Participant, if otherwise legally permissible. The effective date for such retroactive termination will be the last day of the month for which an administrative fee was paid and during which the Participant was eligible for coverage.

4.03.02 **Agreement Termination**. In the event this Agreement is terminated, the Employer agrees that it will be solely responsible for providing prior written notification of the date of such termination to Subscribers who are covered under the Plan, as may be required by applicable federal or state law. AvMed will have no liability whatsoever under this Agreement for the failure by Employer, or its employees, affiliates, subcontractors, agents, or representatives, to timely provide such notification to Subscribers as may be required by applicable federal or state law.

4.03.03 In no event will any retroactive termination of a Participant be made beyond sixty (60) days from notification of the terminating event.

V. DISCLAIMER OF LIABILITY

5.01 Unless prohibited by applicable law, neither Employer nor its agents, servants or employees, nor any Participant, is the agent or representative of AvMed, and none of them will be liable for any acts or omissions of AvMed, its agents or employees, or of a hospital, or physician, or any other person or organization with which AvMed has made or hereafter will make arrangements for the performance of services under this Agreement.

5.02 Unless prohibited by applicable law, neither AvMed nor its agents, servants or employees, nor any Participant, is the agent or representative of the Employer, and none of them will be liable for any acts or omissions of Employer, its agents or employees or any other person representing or acting on behalf of Employer.

5.03 Providers are independent contractors and not the agents or employees of AvMed. Unless prohibited by applicable law, AvMed will 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 professionals or any of their employees or agents who may, from time to time, provide medical services to a Participant under the Plan. Furthermore, AvMed will not be vicariously liable for any negligent act or omission of any of these providers or health professionals who treat a Participant under the Plan.

VI. CLAIM ADMINSTRATION

6.01 As set forth in EXHIBIT B, AvMed will, consistent with the general standards in the industry for third party administration and consistent with the terms of the Plan and the Plan administration policies and procedures adopted by Employer and provided to AvMed:

6.01.01 receive claims for Plan benefits and timely review such claims and requests to determine what amount, if any, is due, payable and/or allowable with respect thereto in accordance with the terms and conditions of the Plan;

6.01.02 disburse or provide, to the person entitled thereto, benefit payments that it determines to be due in accordance with the provisions of the Plan;

6.01.03 conduct initial claims determination and final internal review of denied claims; and

6.01.04 provide access to provider networks as set forth in EXHIBIT B, Part I., E. Network Access.

6.02 AvMed will make initial claims determinations pursuant to the Plan terms. The foregoing is subject to Employer's delegation of full responsibility to AvMed, as named fiduciary, for the final internal review of denied claims appealed in writing by a Plan Participant or beneficiary holding a valid assignment of benefits under the Plan. AvMed agrees to notify Plan Participants and beneficiaries of the right to address a final written appeal to AvMed, as named fiduciary, in circumstances where AvMed makes an initial clam denial pursuant to the terms of the Plan.

6.03 AvMed, acting as fiduciary to the Plan, has been delegated the authority and responsibility to make a full and fair review of each claim denial and to notify the claimant in writing of its decision on review within the time limits and other relating thereto. AvMed acknowledges that this delegation of authority is reflected in the governing document(s) of the Plan and the Summary Plan Description provided to Plan Participants.

VII. FUNDING AND PAYMENT OF CLAIMS

7.01 Employer shall open a depository account in Employer's name ("Employer's Depository Account"), and AvMed agrees to open a disbursement account in AvMed's name ("Account"), which will draft out of the Employer's Depository Account. This funding methodology may be changed if, mutually agreed to by Employer and AvMed in writing, to be in the best mutual interest of Employer and AvMed. Employer agrees to provide AvMed with the necessary signature authority. Employer and AvMed will share banking forms prior to requesting execution, as necessary. Employer and AvMed agree to execute the necessary banking forms.

7.02 AvMed will notify Employer either by facsimile or email of the total dollar amount of claims, prescription drug payments and/or such other Plan-related expenses to be paid as set forth in EXHIBIT B, Part II. This notification will be sent to Employer no less than weekly or as often as a Claims and/or Prescription Drug Payments to be Funded Report is available. The Employer may authorize AvMed to initiate an Automated Clearing House (ACH) transfer of funds or the Employer may initiate an ACH transfer of funds from Employer's Depository Account to the Account. The funds must be received by AvMed within two (2) business days of the original notification. If neither of these ACH methods is acceptable, Employer may wire transfer funds into the Account within the required two (2) business days. If any other funding mechanism is to be used, such as payment by check, additional claim deposits will be required so that the flow of claims and/or prescription drug payments is steady and predictable. In the event a claim exceeds the stop loss deductible amount in a single payment, or a claim exceeds an amount greater than twenty-five thousand dollars ($25,000) in a single payment, AvMed and Employer will determine the appropriate manner in which to proceed with such payment.

7.02.01 AvMed, as the provider of the administrative services as described in this Agreement, will issue checks for Plan benefits and Plan-related expenses in the amount AvMed determines to be proper under the Plan and/or under this Agreement. In the event that sufficient funds are not available to pay all Plan benefits and Plan-related expenses when due from Employer, then AvMed will cease to process claims under this Agreement and will provide notice to the Employer of this action. If the Employer is delinquent in funding the Account, the Employer is immediately required to notify all Participants and all health care providers to be paid of the delinquency of funding. Such notification will be in writing and a copy forwarded to AvMed. If the Employer does not provide such notification within five (5) calendar days of such delinquent funding, AvMed has the right, but not the duty, to notify Participants and health care providers of the delinquency of funding.

7.02.02 Employer agrees that payment will be made and arrive no later than close of business every Wednesday, unless AvMed is delinquent in sending the funding request by the end of the business day on the preceding Monday. In the event Employer begins to miss funding deadlines more than four (4) times within a calendar year, AvMed will establish and require Employer to fund a working deposit equal to no less than two (2) week's average medical paid claims experience, and one (1) month average pharmacy paid claims experience. Average is determined based on an average of prior three (3) months paid claims experience, and will be agreed to in advance by AvMed and the Employer.

7.03 In the event AvMed pays any Participant, hospital, physician, other health care facility or other health professional less than the amount to which they are entitled under the Plan, AvMed will promptly adjust the underpayment by requesting additional funds through the claims funding process. In the event AvMed overpays any Participant, hospital, physician, other health care facility or other health professional entitled to benefits under the Plan, or pays benefits to any Participant, hospital, physician, other health care facility or other health professional not entitled to them, AvMed will take all reasonable steps to recover the overpayment; however, AvMed will not be required to initiate court proceedings to recover an overpayment. AvMed will promptly notify the Employer if it is unsuccessful in recovering any overpayment. AvMed will deposit all amounts recovered in the Account. See EXHIBIT C for payment recovery options. AvMed will only be liable for overpayments to the extent set forth in Section X.

7.04 The Employer and AvMed acknowledge that the Employer will fund the sum of approximately $500,000.00 no later than December 31, 2014 in the Employer's Depository Account, which is to be used as follows:

7.04.01 A working deposit of approximately $186,250.00 for prescription drug coverage offered through AvMed's Pharmacy Benefit Manager.

7.04.02 A working deposit of approximately $313,750.00 for medical claims coverage.

7.05 If these deposits are used in whole or part, AvMed will request the balance as part of the funding request process outlined in EXHIBIT B. Banking and Administration. This amount will be reviewed periodically by AvMed; if the amount proves insufficient based on an average of prior three (3) months paid claims experience, Employer agrees to work with AvMed to reach an appropriate increase the deposit..

7.06 It is understood that AvMed will not advance its own funds for payment of any medical, interest or pharmacy expenses incurred by the Participants.

VIII. RECORD RETENTION AND REVIEW

8.01 Employer may perform claims or performance audits of AvMed's performance under this Agreement. The audits may be performed by the Employer or its designated agent as determined by

the Employer in its discretion. Upon thirty (30) days' advance written request, AvMed will make available to Employer or its designated agent, for its audit or inspection during regular business hours at the place or places of business where it is maintained by AvMed, documents relating to this Agreement, the payment of claims together with any supporting documentation or material necessary in the determination or calculation of all claims and costs charged to the Plan. Any audit will be conducted pursuant to the Claim Audit Agreement attached as EXHIBIT H. However, Employer will only be responsible for any of AvMed's costs or expenses that exceed two-thousand eight hundred dollars ($2,800).

8.02 Any release of confidential records or information to the Employer or its designee will be made subject to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and subject to the Confidentiality Agreement attached hereto as EXHIBIT D. Employer agrees that it will ensure that any designee or other third party who will have access to such confidential records or information executes such documentation required by AvMed to effectuate the purpose of this Section and a HIPAA Business Associate Agreement, if appropriate. No information will be furnished in the absence of such documentation.

8.03 AvMed agrees to provide to Employer or Employer's designee claim or payment data recorded for or otherwise integrated into AvMed's data processing systems during the ordinary course of business for the purpose of populating the applicable medical or pharmacy claims database (claim or payment data will also be available to Employer pursuant to Section VIII). Employer shall provide AvMed with certification that the Plan document has been amended as required by the HIPAA Privacy Rule, 45 C.F.R. Parts 160 and 164 ("HIPAA Privacy Rule") to permit disclosures of Protected Health Information (PHI) to Employer for Plan administration purposes and that Employer agrees to the conditions set forth in that Plan amendment: copies of any authorizations of Participants to use to disclose PHI (and any later changes to or revocations of such authorizations); notice of any restrictions on the use to disclosure of PHI that Employer agrees to under the HIPAA Privacy Rule; and notice of any requests that communications be sent to a Participant by an alternative means or at an alternative location that Employer agrees to under the HIPAA Privacy Rule. Employer shall not request that AvMed use or disclose PHI in any manner that would not be permissible under the HIPAA Privacy Rule if done by Employer, except that AvMed may use or disclose PHI for purposes of data aggregation and the management and administration activities of AvMed.

8.04 Notwithstanding the above, AvMed will provide to Employer any information or data required by Employer in connection with any dispute or litigation regarding a claim for benefits under the Plan or in connection with an audit by Employer or its agent of claims or costs charged to the Plan.

8.05 All claims data and records will be maintained by AvMed for no less than the required prevailing statutory period for record retention and in accordance with the privacy and confidentiality safeguards required by law. AvMed will maintain all records made or received in connection with this Agreement for the period of time required by the Florida Public Records law, Chapter 119 of the Florida Statutes, and associated retention schedules and/or pursuant with all applicable federal statutory requirements. If this Agreement terminates, AvMed shall deliver to Employer or Employer's designee, at Employer's request, all such books, records and documents, pursuant to the confidentiality provisions of this Agreement, that are the property of Employer or as required by applicable law, subject to AvMed's right to retain copies of any records it deems appropriate. Employer will be required to pay AvMed reasonable charges for transportation or duplication of such records to be determined at time of request for such documents and records. . AvMed agrees to cooperate with Employer on all reasonable requests for claim data and record transfer to Employer, or Employer's designee.

8.06 The obligations set forth in this Section will survive termination of this Agreement.

IX. NON-DISCLOSURE OF PROPRIETARY INFORMATION

9.01 Employer and AvMed each acknowledge that in contemplation of entering into this Agreement (and as a result of the contractual relationship created hereby), each party has revealed and disclosed, and shall continue to reveal and disclose to the other, information which is proprietary and/or confidential information of the other party to the extent permitted by law.

9.02 To the extent permitted by law, Employer and AvMed agree that each party shall (1) keep such proprietary and/or confidential information of the other party, which qualifies under Florida law as a trade secret, in strict confidence; (2) not disclose confidential information of the other party to any third-parties or to any of its employees not having a legitimate business need to know such information; and (3) shall not use confidential information of the other party for purposes not directly related to and necessary for the performance of its obligations under this Agreement, unless required to do so by a court of competent jurisdiction or regulatory agency having authority to require such disclosure.

9.03 Any information which AvMed reasonably deems to be proprietary in nature or any information which AvMed reasonably believes it cannot disclose due to applicable state and/or federal privacy restrictions will not be disclosed to the Employer at any time. Employer will have no interest in, nor will AvMed have any obligation to provide to Employer any claim or payment data recorded for or otherwise integrated into AvMed's data processing systems during the ordinary course of business provided; however, that claim or payment data will be available to Employer pursuant to Section VIII, as provided for in Sections 9.01 and 9.02.

9.04 The obligations set forth in this Section will survive termination of this Agreement.

X. LIABILITY AND INDEMNITY

10.01 In performing its obligations under this Agreement, AvMed neither insures nor underwrites any liability of the Employer under the Plan but, with respect to the Employer as/or Plan Administrator acts only as the provider of the administrative services described in this Agreement.

10.02 AvMed will have no duty or obligation to defend against any action or proceeding brought to recover Plan benefits. AvMed will, however, make available to the Employer and its counsel, such evidence relevant to such action or proceeding as AvMed may have as a result of its administration of the contested benefit determination.

10.03 Except as otherwise explicitly provided in this Agreement or in the Business Associate Agreement between AvMed and Employer, the Employer will accept the tender of defense and retain the liability for all Plan benefit claims and all expenses incident to the Plan and, acting as an Employer and not as a Plan fiduciary, agrees to indemnify and defend AvMed for and hold it, its directors, officers and employees, harmless from all amounts and expenses, including reasonable attorney's fees and court costs for which AvMed may become liable:

10.03.1 for any state premium, or similar tax, or similar benefit-or plan-related charge, surcharge or assessment, however denominated, including any penalties and interest payable with respect thereto, assessed against AvMed or the Employer on the basis of and/or measured by the amount of Plan benefits administered by AvMed pursuant to this Agreement;

10.03.2 arising from any lawsuit or legal proceeding to recover benefits under the Plan;

10.03.3 arising from any lawsuit or legal proceeding, whether made by or on behalf of any Plan Participants, any governmental body or bodies, or any other person, regarding unclaimed or abandoned property, or laws relating thereto, or any escheat obligations, as related to Plan benefits administered pursuant to this Agreement, including any penalties and interest payable with respect thereto;

10.03.4 arising from any allegation of a breach of confidentiality arising out of release of confidential information to Employer by AvMed, or its agent or arising out of any improper use of such confidential information by Employer or its agent; and/or

10.03.5 in consequence of any acts or omissions occurring, in whole or in part, during the operation of this Agreement alleged to be a breach of fiduciary duty under any applicable state and federal statutes, or otherwise provided for in Section 10.06. AvMed will give not less than ten (10) days written notice of such lawsuit or legal proceeding to Employer.

10.03.6 notwithstanding any of the foregoing, Employer and AvMed will not assume their interests are adverse without first making a reasonable effort to determine the relevant facts within the context of this Agreement and the terms of the Plan as it applies to the operation of the Plan

10.03.7 in the event of any conflict in terms, interpretation, applicability, scope or extent of indemnity, defense, or hold harmless contained within Section X. Liability and Indemnification of this Agreement and Section 5. Mutual Indemnification of the Business Associate Agreement (BAA) between Employer and AvMed, then both Employer and AvMed agree that Section 5. Mutual Indemnification of the BAA shall govern only as the controlling contract related to the subject matter and topics within the BAA

10.04 This indemnity will survive the termination of this Agreement.

10.05 In the event of a lawsuit or legal proceeding is instituted by a third party against the Employer and/or AvMed concerning any matter under this Agreement, the Plan, including a suit for Plan benefits, Employer and AvMed will agree to be defended by legal counsel retained by Employer, unless either party believes that there is any actual, potential or perceived conflict of interest in being represented by same counsel in which case each party shall have sole authority to select legal counsel of its choice with reasonable attorney fees covered as provided for in Section 10.03. Employer and AvMed are required to give not less than ten (10) business days written notice of such lawsuit or legal proceeding to the other party. Notwithstanding the foregoing, the Employer and AvMed will not assume their interests are adverse without first making a reasonable effort to determine the relevant facts within the context of this Agreement and the terms of the Plan as it applies to the operation of the Plan. Employer and AvMed will use best efforts to cooperate fully to determine the relevant facts within the context of the terms and provisions of this Agreement and, the applicable terms of the Plan.

10.06 Notwithstanding any provision in this Agreement to the contrary, with respect to claims administration services, AvMed will indemnify, defend and hold the Employer harmless for any and all liabilities, claims, suits, causes of action, damages, proceedings, assessments, penalties, costs and expenses of whatever nature, (including reasonable attorney's fees and court costs) arising out of an act or omission of AvMed in connection with claims administration that:

10.06.01 when taken together with other acts or omissions, in whole or in part, of AvMed, constitutes a material breach on the part of AvMed to perform its obligations under this Agreement; or

10.06.02 was grossly negligent or intentional act or omission.

10.07 Notwithstanding the above, AvMed's duty to indemnify, defend and hold Employer harmless will not extend to acts or omissions, in whole or in part, of the Employer, its officers, director, or employees. The Employer will give AvMed prompt and timely notice of any fact or condition which comes to its attention which may give rise to a claim of indemnity under this Section. Employer and AvMed are required to give not less than ten (10) days written notice of a lawsuit or legal proceeding to the other party. Notwithstanding the foregoing, the Employer and AvMed will not assume their interests

are adverse without first making a reasonable effort to determine the relevant facts within the context of this Agreement and the terms of the Plan as it applies to the operation of the Plan.

10.08 This indemnity will survive the termination of the Agreement.

10.09 To avoid misunderstanding by third-parties concerning the respective duties and liabilities hereunder, Employer and AvMed agree not to use the other's name, logo, service marks, trademarks or other identifying information without the prior written approval of the other. Notwithstanding the above, Employer may refer to AvMed as the claims administrator in the Plan documents, summary plan description, and other Plan Participant communications.

10.10 Employer retains full discretionary authority to settle or compromise any lawsuit or legal proceeding based on a claim for Plan benefits. The Employer's defense and/or settlement, as provided herein, will be at the Employer's direction and expense, except that the Employer can recover the expenses of the defense and/or settlement if the Employer is entitled to indemnification pursuant to this Agreement. In the event a lawsuit or legal proceeding is instituted by a third-party against Employer and/or AvMed concerning a claim for Plan benefits, the affected party will give no less than ten (10) business days written notice of such lawsuit or legal proceeding to the other party. Employer and AvMed will cooperate fully to determine the relevant facts within the context of the terms and provisions of this Agreement and, the applicable terms of the Plan. Notwithstanding the foregoing, the Employer and AvMed will not assume their interests are adverse without first making a reasonable effort to determine the relevant facts within the context of this Agreement and the terms of the Plan as it applies to the operation of the Plan.

10.11 Unless prohibit by applicable law, to avoid misunderstanding by third-parties concerning their respective duties and liabilities under this Agreement, neither the Employer nor AvMed will make any representations regarding the other or this Agreement to third-parties. No representation regarding this Agreement as it may or may not affect the other party's liability under this Agreement will be made to third-parties (other than to AvMed's or Employer's legal counsel) unless disclosed in answer to a lawsuit or subject to a subpoena or other valid order of a court of law having jurisdiction over the pertinent legal proceedings, or required to be disclosed under Florida's Public Records law, unless AvMed notifies Employer in writing of AvMed's filing of a Motion for Protective Order or objections to the disclosure asserting proper Florida Public Records.

10.12 Nothing in this Agreement shall constitute a waiver of Employer's sovereign immunity, or the limits of Florida Statutes, Section 768.28, nor shall anything included herein be construed as consent by Employer to be sued by third-parties in any matter arising out of this Agreement.

XI. CHOICE OF LAW

11.01 To the extent not preempted by federal law, the Agreement shall be construed, interpreted and enforced in accordance with the laws of the State of Florida without giving effect to the choice of law principles thereof or any canon, custom or rule of law requiring construction against the drafter. Venue of any action will be in Broward County, Florida, notwithstanding any conflicts of law provisions that would require the application of the law of a different state. Except as set forth in the indemnification provisions above, should Employer and AvMed be involved in legal action arising under, or connected to this Agreement, each party will be responsible for their own attorney's fees and court costs as provided herein. Both Employer and AvMed hereby agree to waive a jury trial, and will proceed to a trial by judge, if necessary.

XII. MODIFICATION OF PLAN AND ADMINISTRATIVE DUTIES AND CHARGES

12.01 AvMed will have the right to revise the administration charge subject to negotiations and mutual agreement by Employer in Extended Contract Years 4 and 5 of this Agreement.

12.02 Modification or amendment of the Plan as described in Exclusive Provider Network (HMO) Summary Plan Document and Point of Service (POS) Summary Plan Document, collectively see, EXHIBIT A, will be communicated in writing by the Employer to AvMed no less than sixty (60) days prior to the effective date of such change. Implementation of the modification or amendment will be mutually agreed upon by the Employer and AvMed subject to (if applicable) mutually agreed upon: (a) data processing systems changes, retroactive effective dates, (b) payment by Employer of increase in administrative fees and other adjustments and (c) procedure changes necessitated by the modification or amendment. Notwithstanding the above, changes required under Federal law will be implemented on the date required under that Federal law. The cost of notification to Plan Participants of changes made by the Employer will be the responsibility of the Employer.

12.03 The benefit design of the Plan, as described in the Exclusive Provider Network (HMO) Summary Plan Document and Point of Service (POS) Summary Plan Document, collectively see EXHIBIT A, is based on AvMed's core benefit packages as offered to AvMed's large group clients. AvMed makes changes to these core offerings from time to time. AvMed will give notice to the Employer no less than sixty (60) days prior to renewal of any change that affects the administration or benefit design of the Plan. Implementation of the modification or amendment will be mutually agreed upon in writing by the Employer and AvMed prior to implementation of such change. Notwithstanding the above, changes required under Federal law will be implemented on the date required under the Federal law. The cost of notification to Plan Participants of changes made by AvMed will be the responsibility of AvMed.

12.04 The term 'Plan' as used in this Agreement will include each such modification or amendment as of the implementation date agreed upon by Employer and AvMed.

12.05 Modification of the duties as described in EXHIBIT B, or any other section or exhibit incorporated herein, unless specifically provided for otherwise in the Agreement, section or exhibit, will be by mutual agreement of the Employer and AvMed. Any such modification (and the revised charge, if any, applicable thereto) will be evidenced by amendment to Agreement, between Employer and AvMed that, upon execution, will become a part of this Agreement.

XIII. MODIFICATION OF AGREEMENT

13.01 This Agreement constitutes the entire contract between the Employer and AvMed concerning the subject matter hereof. All prior or contemporaneous agreements, promises, negotiations or representations relating to the subject matter of this Agreement not expressly set forth in this Agreement, including its exhibits, are of no force or effect. No modifications or amendment hereto will be valid unless in writing and signed by an authorized representative of each of Employer and AvMed, except that modification of administration charges pursuant to Section XII above may be made by written notice to Employer by AvMed, and mutually agreed upon.

XIV. MISCELLANEOUS

14.01 **Applicability of Law**. The provisions of this Agreement will be deemed to have been modified by Employer and AvMed, and will be interpreted, so as to comply with the laws and regulations of the State of Florida and the United States.

14.02 **Assignment**. This Agreement, and all rights and benefits related thereto, may not be assigned by the Employer and AvMed without written consent by both Employer and AvMed.

14.03 **Clerical Errors**. Clerical error(s) will neither deprive any individual Participant of any benefits or coverage provided under this Agreement nor will such error(s) act as authorization of benefits or coverage for the Participant that is not otherwise validly in force.

14.04 **Entirety of Agreement**. This Agreement and all applicable schedules, exhibits, riders and any other attachments and endorsements, constitute the entire agreement between the Employer and AvMed.

No modification (or oral representation) or amendment of this Agreement will be of any force or effect unless it is in writing and signed by both Employer and AvMed.

14.05 **Gender**. Whenever used, the singular will include the plural and the plural the singular and the use of any gender will include all genders.

14.06 **HIPAA Privacy**. Employer will provide AvMed with notice of the privacy practices that Employer provides to Subscribers in accordance with HIPAA, as well as any subsequent changes to such notices. Employer will provide AvMed with any changes to, or revocation of, permission by a Participant to use or disclose protected health information (PHI) if such changes affect AvMed's permitted or required uses or disclosures. Employer will notify AvMed of any restriction to the use or disclosure of PHI that Employer has agreed to in accordance with the HIPAA Privacy Rule. Employer will not request that AvMed use or disclose PHI in any manner that would not be permissible under the HIPAA Privacy Rule if done by the Employer, except that AvMed may use or disclose PHI for purposes of data aggregation and the management and administration activities of AvMed.

14.07 **Membership Cards**. Cards issued by AvMed to Participants pursuant to this Agreement are for purposes of identification only. Possession of an AvMed identification card confers no right to health services or other benefits under this Agreement. To be entitled to such services or benefits the holder of the card must, in fact, be a Participant on whose behalf all applicable charges under this Agreement have actually been paid and accepted by AvMed.

14.08 **Non-Waiver**. The failure of AvMed or the Employer to enforce any of the provisions of this Agreement or to exercise any options herein provided or to require timely performance by the other party of any of the provisions herein, will not be construed to be a waiver of such provisions nor will it affect the validity of this Agreement or any part thereof or the right of AvMed or the Employer to thereafter enforce each and every such provision.

14.09 **Notice**. Any notice intended for and directed to Employer or AvMed under this Agreement, unless otherwise expressly provided, should be sent certified mail RRR by United States mail, or by email to Employer or AvMed as follows:

If to AvMed, to:

AvMed, Inc.
Attn: Jim Repp, Sr. Vice President, Member
Relationship Management
9400 South Dadeland Blvd.
Suite 370
Miami, Florida 33156

jim.repp@avmed.org

If to Employer, to:

City of Sunrise
Attn: Bill Mason, Risk Manager
Risk Management Division
10770 West Oakland Park Boulevard,
3rd Floor
Sunrise FL 33351
bmason@sunrisefl.gov

Notice shall be effective upon date received or date email is confirmed to have been delivered.

14.10 **Plan Administration**. AvMed may from time to time adopt reasonable policies, procedures, rules, and interpretations consistent with the terms of the Agreement and the Plan to promote the orderly and efficient administration of this Agreement.

14.11 **Premium Tax/Surcharge**. If any government entity will impose a premium tax or surcharge, then the sums due from the Employer under the terms of this Agreement will be increased by the amount of such premium tax or surcharge, unless the imposed premium tax or surcharge is included in the premium rates determined by the Employer's actuary.

14.12 **Statute of Limitations**. A claim which has not been timely filed with AvMed will be considered waived if, on the date notice of it is received by AvMed, that claim would otherwise have been barred by any Florida Statute of Limitations if asserted in civil court.

14.13 **Summary Plan Description**. Subject to approval by Employer, AvMed will provide a copy of the Exclusive Provider Network (HMO) Summary Plan Document and/or Point of Service (POS) Summary Plan Document for distribution by Employer to any Subscriber under the Plan. Employer will provide a copy of the Exclusive Provider Network (HMO) Summary Plan Document and/or Point of Service (POS) Summary Plan Document to any Participant under the Plan, upon request of Participant.

14.14 **Third Party Beneficiary**. This Agreement is entered into exclusively between the Employer and AvMed. This Agreement is intended only to benefit the Employer and does not confer any rights on any third parties.

14.15 **Waiver**. A claim which has not been timely filed with AvMed in accordance with the provisions of the applicable governing document will be considered waived.

14.16 **Exhibits.** All exhibits attached to this Agreement shall be considered incorporated into this Agreement as if fully set forth herein.

14.17 **Headings**. Part and section headings are intended for the purpose of description only and shall not be used for purposes of interpretation of this Agreement.

XV. PROVISION FOR ORDER OF DOCUMENT GOVERNANCE

15.01 In the event there is a conflict or dispute between Employer and AvMed regarding the performance of services or administration of this Agreement, Employer and AvMed agree the following documents shall govern in order of priority listed below:

1. Administrative Service Agreement, and related exhibits
2. Letter regarding the nine (9) negotiated terms and conditions
   From AvMed, date stamped received by the City on July 29, 2014
   and signed by AvMed's Strategic Sales Consultant, Iliana Menendez.
3. Request for Proposal #01012015 Third Party Administrator for
   Self-Funded Group Health Plan, Including Pharmacy Benefit
   Management
4. Request for Proposal #01012015 responses by AvMed, dated 6/24/14

These documents shall be considered incorporated into this Agreement as if fully set forth herein.

XVI. SEVERABILITY

16.01 If any term or provision of this Agreement or the application thereof to any person or circumstances shall, to any extent, be held invalid or unenforceable, the remainder of this Agreement, or the application of such terms or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected, and every other term and provision of this Agreement shall be deemed valid and enforceable to the extent permitted by law.

IN WITNESS WHEREOF, Employer and AvMed hereto have caused this Agreement to be executed by their respective duly authorized officers effective as of the date first written above.

AvMed, Inc.

By: James Repp

Title: Sr. Vice President, Member Relationship Management

Date: 7/17/2015

Address: 9400 S. Dadeland Blvd.

Miami, FL 33156

Facsimile: (305) 671-4764

Email: jim.repp@avmed.org

Signature

City of Sunrise

By: Bill Mason

Title: Risk Manager

Date: 7/8/2015

Address: City of Sunrise, Risk Management Division

10770 W. Oakland Park Blvd, 3rd Floor

Sunrise, FL 33351

Facsimile: (954) 572-2382

Email: bmason@sunrisefl.gov

Signature

Resolution # 14-07

EXHIBIT A. EXCLUSIVE PROVIDER NETWORK (HMO) SUMMARY PLAN DOCUMENT AND POINT OF SERVICE (POS) SUMMARY PLAN DOCUMENT

Attach Summary Plan Description

Summary Plan Description
of the
HMO Option
for the
City of Sunrise Group Medical Plan

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AVMED CORPORATE OFFICE
9400 S. DADELAND BLVD.
MIAMI, FL 33156-9004

AVMED MEMBER SERVICES - ALL AREAS
1-844-263-2369

SERVICE AREAS

MIAMI
9400 South Dadeland Boulevard
Miami, Florida 33156-9004
(305) 671-5437
(800) 432-6676
Miami-Dade

FT. LAUDERDALE
13450 West Sunrise Boulevard
Suite 370
Sunrise, Florida 33323-2947
(954) 462-2520
(800) 368-9189
Broward
Palm Beach

ORLANDO
1800 Pembrook Drive
Suite 190
Orlando, Florida 32810
(407) 539-0007
(800) 227-4848
Lake
Orange
Osceola
Seminole

GAINESVILLE
4300 Northwest 89th Boulevard
Post Office Box 749
Gainesville, Florida 32606-0749
(352) 372-8400
(800) 346-0231
Alachua
Bradford
Citrus
Columbia
Dixie
Gilchrist
Hamilton
Levy
Marion
Suwannee
Union

JACKSONVILLE
1300 Riverplace Boulevard
Suite 640
Jacksonville, Florida 32207
(904) 858-1300
(800) 227-4184
Baker
Clay
Duval
Nassau
St. Johns

TAMPA BAY/ SOUTHWEST FLORIDA
1511 North Westshore Boulevard
Suite 450
Tampa, Florida 33607
(813) 281-5650
(800) 257-2273
Hernando
Hillsboro
Lee
Pasco
Pinellas
Polk
Sarasota

I. INTRODUCTION

Your employer has contracted with AvMed, Inc. (hereinafter 'AvMed') to arrange for the provision of Medical Services or benefits which are Medically Necessary for the diagnosis and treatment of Participants through a network of contracted independent Physicians and Hospitals and other health care providers.

AvMed, in arranging for the delivery of Medical Services or benefits, does not directly provide these Medical Services or benefits. AvMed arranges for the provision of said services in accordance with the covenants and conditions contained in this Summary Plan Description. AvMed will rely upon the statements of the Participant in his application in providing coverage and benefits hereunder.

You Must Enroll to Receive Benefits! You must affirmatively enroll to receive benefits under the Plan, as explained in Section III (ELIGIBILITY). If you do not take the actions outlined in Section III to affirmatively enroll to receive benefits, you will **not** be entitled to any benefits of any kind under this Plan.

This document is a Summary Plan Description ('SPD') of the medical benefits provided to you by the City of Sunrise (the 'Employer') under the City of Sunrise Group Medical Plan (hereinafter, the 'Plan'). This SPD is made available for your reference and is subject to various legal requirements, including the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Unless otherwise noted in this document, if the terms of this document and the terms of the Plan conflict, the Plan document shall control.

The Employer may designate any other third-party administrators or claims administrators to carry out certain Plan duties and responsibilities. The Employer is responsible for formulating and carrying out all rules and procedures necessary to administer the Plan. The Employer, as Plan Sponsor, has the discretionary authority to (1) make decisions regarding the interpretation or application of Plan provisions, (2) determine the rights, eligibility, and benefits of Participants and beneficiaries under the Plan, and (3) review claims under the Plan. The Employer may delegate to a third party any or all such discretionary authority described above. Benefits under the Plan will be paid only if the Employer, as Plan Sponsor, or its designee or delegate decides in its discretion that the applicant is entitled to them.

The Plan may be amended at any time. Such amendments, for example, may (1) increase or otherwise change the cost to you for coverage, (2) change the type of benefits provided under the Plan, the conditions of participation and any other terms of the Plan, (3) require additional contributions from Participants, or (4) terminate the Plan in whole or in part at any time. Plan provisions will be administered in accordance with any appropriate collective bargaining agreement.

The Plan is not intended to and does not cover or provide any Medical Services or benefits that are not Medically Necessary for the diagnosis and treatment of the Participant. The determination as to which services are Medically Necessary shall be made by the Plan subject to the terms and conditions of the Plan. Claims for benefits are to be sent to AvMed.

Notwithstanding any references for definitional purposes to the contrary, this Plan is not an HMO product and is not subject to Chapter 641 of the Florida Statutes, nor is a Participant of the Plan afforded any individual rights under Chapter 641 of the Florida Statutes. Premiums for employees and their families are paid in part by the Employer as Plan Sponsor out of its general assets, and in part by employees' after-tax and before tax payroll deductions.

The Medical and Hospital Services covered by the Plan shall be provided without regard to the race, color, religion, physical handicap, or national origin of the Participant in the diagnosis and treatment of patients; in the use of equipment and other facilities; or in the assignment of personnel to provide services, pursuant to the provisions of Title VI of the Civil Rights Act of 1964, as amended, and the Americans with Disabilities Act of 1990.

II. DEFINITIONS

For further definitions, go to www.healthcare.gov/glossary to review the glossary provided as a result of the Affordable Care Act.

As used in this SPD, each of the following terms shall have the meaning indicated:

2.01 **Accidental Dental Injury** means an injury to sound natural teeth caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

2.02 **Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part), for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part), for a benefit resulting from the application of any Utilization Management Program, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary; and including a cancellation or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

2.03 **Applied Behavior Analysis** means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. Applied Behavior Analysis services shall be provided by an individual certified pursuant to Section 393.17, *Florida Statutes*, or an individual licensed under Chapter 490 or Chapter 491, *Florida Statutes* or if applicable, equivalent or similar state laws of another state.

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

2.05 **Autism Spectrum Disorder** means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

2.05.01 Autistic disorder;

2.05.02 Asperger's syndrome;

2.05.03 Pervasive developmental disorder not otherwise specified.

2.06 **AvMed Network** means the providers and facilities that have contracted with AvMed to provide covered services to Participants. The Participants' Copayment and/or Coinsurance responsibilities are outlined in the Schedule of Benefits.

2.07 **Behavioral Health** is the scientific study of the emotions, behaviors and biology relating to a person's mental well-being, their ability to function in everyday life and their concept of self. Behavioral Health is the preferred term to mental health. A person struggling with his or her Behavioral Health may face stress, depression, anxiety, relationship problems, grief, addiction, ADHD or learning disabilities, mood disorders, or other psychological concerns. Counselors, therapists, life coaches, psychologists, nurse practitioners or Physicians can help manage Behavioral Health concerns with treatments such as therapy, counseling, or medication.

2.08 **Calendar Year** means the twelve-month period beginning January 1st and ending December 31st.

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

2.10 **Claimant** means a Participant or a Participant's authorized representative acting on behalf of the Participant. AvMed may establish procedures for determining whether an individual is authorized to act on behalf of the Participant. If the Claim is an Urgent Care or Pre-Service Claim, a Health Professional, with knowledge of the Participant's medical condition, shall be permitted to act as the Participant's authorized representative and will be notified of all approvals on the Claimant's behalf. In the event of an Adverse Benefit Determination, AvMed will notify both the Participant and the Heath Professional.

2.11 **Coinsurance** means the amount a Participant must pay once the Deductible has been met, if applicable, and is expressed as a percentage of the contracted rate for the covered benefit.

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

2.13 **Contract Year** means the period of 12 consecutive months commencing on the effective date of the Plan. **Benefit Period**, however, refers to a Calendar Year of January 1st through December 31st. Such Benefit Period will terminate on the earliest of the following dates:

2.13.01 the last day of each Calendar Year; or

2.13.02 the day the Participant ceases to be covered for health care benefits under the Plan.

2.14 **Core Benefits** means all benefits provided under Section VIII (SCHEDULE OF BASIC BENEFITS), subject to the limitations of Section IX (LIMITATIONS OF BASIC BENEFITS) and the exclusions of Section X (EXCLUSIONS FROM BASIC BENEFITS).

2.15 **Copayment** means the portion of the cost, in addition to the prepaid premium amounts, which the Participant is required to pay at the time certain health services are provided under the Plan. The Copayment may be a specific dollar amount or a percentage of the cost. The Participant is responsible for the payment of any Copayments directly to the provider of the health services at the time of service.

2.16 **Covered Dependent** means any Dependent of a Covered Employee who meets all applicable requirements of the Plan and is enrolled in the Plan.

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

2.18 **Custodial Care** means services and supplies that are furnished mainly to train or assist in the activities of daily living, such as bathing, feeding, dressing, walking and taking oral medications. "Custodial Care" also means services and supplies that can be safely and adequately provided by persons other than licensed health professionals, such as dressing changes and catheter care, or that ambulatory patients customarily provide for themselves, such as ostomy care, administering insulin and measuring and recording urine and blood sugar levels.

2.19 **Dental Care** means dental x-rays, examinations and treatment of the teeth or any services, supplies or charges directly related to:

2.19.01 the care, filling, removal or replacement of teeth, or

2.19.02 the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth, that are customarily provided by dentists (including orthodontics reconstructive jaw surgery, casts, splints and services for dental malocclusion).

2.20 **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

2.20.01 Serious jeopardy to the health of a patient, including a pregnant woman or fetus.

2.20.02 Serious impairment to bodily functions.

2.20.03 Serious dysfunction of any bodily organ or part.

2.20.04 With respect to a pregnant woman:

a. That there is inadequate time to effect safe transfer to another Hospital prior to delivery;

b. That a transfer may pose a threat to the health and safety of the patient or fetus; or

c. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

2.20.05 Examples of Emergency Medical Conditions include, but are not limited to: heart attack, stroke, massive internal or external bleeding, fractured limbs or severe trauma.

2.21 **Emergency Medical Services and Care** means medical screening, examination and evaluation by a Physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Physician to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a covered service by a Physician necessary to relieve or eliminate the Emergency Medical Condition within the service capability of the Hospital.

2.21.01 **In-area emergency** does not include elective or routine care, care of minor illness or care that can reasonably be sought and obtained from the Participant's Primary Care Physician. The determination as to whether or not an illness or injury constitutes an emergency shall be made by AvMed and may be made retrospectively based upon all information known at the time the patient was present for treatment.

2.21.02 **Out-of-area emergency** does not include care for conditions for which a Participant could reasonably have foreseen the need of such care before leaving the Service Area or care that could safely be delayed until return to the Service Area. The determination as to whether or not an illness or injury constitutes an emergency shall be made by AvMed and may be made retrospectively based upon all information known at the time the patient was present for treatment.

2.22 **Employer** means City of Sunrise, 10770 W. Oakland Park Blvd, Sunrise, Florida, 33351. The Employer may also be referred to herein as the 'Plan Sponsor'.

2.23 **Essential Health Benefits** has the meaning under section 1302(b) of the Federal Act and applicable regulations. The ten categories of Essential Health Benefits are:

2.23.01 ambulatory patient services;

2.23.02 emergency services;

2.23.03 hospitalization;

2.23.04 laboratory services;

2.23.05 maternity and newborn care;

2.23.06 mental health and substance use disorder services (including behavioral health treatment);

2.23.07 pediatric services (including oral and vision care);

2.23.08 prescription drugs;

2.23.09 preventive and wellness services and chronic disease management; and

2.23.10 Rehabilitation and Habilitation Services and devices.

2.24 **Exclusion** means any provision of the Plan whereby coverage for a specific hazard or condition is entirely eliminated.

2.25 **Experimental and/or Investigational**. For the purposes of this Plan a medication, treatment, device, surgery or procedure may be determined by AvMed in its discretion, to be Experimental and/or Investigational if any of the following applies:

2.25.01 The FDA has not granted the approval for general use; or

2.25.02 There are insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

2.25.03 There is no consensus among practicing Physicians that the medication, treatment, therapy, procedure or device is safe or effective for the treatment in question or such medication, treatment, therapy, procedure or device is not the standard treatment, therapy, procedure or device utilized by practicing Physicians in treating other patients with the same or a similar condition; or

2.25.04 Such medication, treatment, procedure or device is the subject of an ongoing Phase I or Phase II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question. Notwithstanding the previous sentence, approved clinical trials, as such term is defined by Section 2709 of the Public Health Service Act ("PHSA") will not be treated as Experimental and/or Investigational if the requirements of Section 2709 of the PHSA are satisfied.

2.26 **Full-Time Student or Part-Time Student** means one who is attending a recognized and/or accredited college, university, vocational, or secondary school and is carrying sufficient credits to qualify as a Full-Time or Part-Time Student in accordance with the requirements of the school.

2.27 **Group Health Insurance** (for purposes of Section XI (COORDINATION OF BENEFITS) means that form of health insurance covering groups of persons under a master Group Health Insurance policy issued to any one of the groups listed in Sections 627.552 (employee groups), 627.553 (debtor groups), 627.554 (labor union and association groups), and 627.5565 (additional groups), *Florida Statutes*.

2.27.01 The terms 'amount of insurance' and 'insurance' include the benefits provided under a plan of self-insurance.

2.27.02 The term 'insurer' includes any person, entity or governmental unit providing a plan of self-insurance.

2.27.03 The terms 'policy', 'insurance policy', 'health insurance policy' and 'Group Health Insurance policy' include plans of self-insurance providing health insurance benefits.

2.28 **Habilitation Services** are services provided in order for a person to attain and maintain a skill or function never learned or acquired due to a disabling condition. They are services that are deemed necessary to meet the needs of individuals with developmental disabilities in programs designed to achieve objectives of improved health, welfare and the realization of individual's maximum physical, social, psychological and vocational potential for useful and productive activities.

2.28.01 Covered services consist of physical therapy, speech therapy, and occupational therapy that is provided for developmental delay, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder. Therapy services must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate state licensing board and must be furnished under the direction and supervision of a Physician or an advanced practice nurse in accordance with a written treatment plan established or certified by the treating Physician or advanced practice nurse.

2.28.02 Covered services take place in a participating non-residential setting separate from the home or facility in which the Participant lives.

2.28.03 Services are covered up to the point where no further progress can be documented. Services are not considered a covered benefit when measurable functional improvement is not expected or progress has plateaued.

2.28.04 Covered Habilitation Services do not include activities or training to which the Covered Employee may be entitled under federal or state programs of public elementary or secondary education or federally aided vocational rehabilitation.

2.28.05 Non-covered Habilitation Services include, but are not limited to: residential based Habilitation Services, home-based Habilitation Services, institutional based Habilitation Services, personal assistance/ attendant care services; errand services; transportation to and from training facilities unless provided by training facility; family education and training, family support services; prevocational services designed to assist a Participant in acquiring basic work skills; supportive employment habilitation; respite care/ camps/ hotel respite, room and board; services that are purely educational in nature, personal training or life coaching; Custodial Care (care that is provided primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety and could be provided by people without professional skills or training).

2.29 **Health Professionals** means Physicians, osteopaths, podiatrists, chiropractors, physician assistants, nurses, social workers, pharmacists, optometrists, clinical psychologists, nutritionists, occupational therapists, physical therapists and other professionals engaged in the delivery of health care services, who are licensed and practice under an institutional license, individual practice association or other authority consistent with State law and who are Participating Providers of AvMed.

2.30 **Home Health Care Services (Skilled Home Health Care)** means services that are provided for a Participant who does not require confinement in a Hospital or Other Health Care Facility. Such services include, but are not limited to, the services of professional visiting nurses or other health care personnel for services covered under the Plan. A visit is limited to a period of two hours or less.

2.31 **Hospice** means a public agency or private organization that is duly licensed by the appropriate state entity to provide Hospice services and with whom AvMed has a current provider agreement. Such licensed entity must be principally engaged in providing pain relief, symptom management and supportive services to terminally ill Participants.

2.32 **Hospital** means a facility properly licensed pursuant to Chapter 395, *Florida Statutes* or if applicable, equivalent or similar state laws of another state, that offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent. The term Hospital does not include: an Ambulatory Surgery Center; Skilled Nursing Facility; stand-alone Birthing Center; convalescent, rest or nursing home; or facility which primarily provides Custodial, educational or rehabilitative therapies.

2.32.01 If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Associate, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the score of covered services. It only expands the setting where covered services can be performed for coverage purposes.

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

2.33.01 generally and customarily provided by acute care general Hospitals in accordance with the standards of acceptable community practice;

2.33.02 performed, prescribed or directed by Participating Providers; and

2.33.03 Medically Necessary for conditions which cannot be adequately treated in Other Health Care Facilities or with Home Health Care Services or on an ambulatory basis.

2.34 **Hospitalist/Admitting Panelist** means a Physician who specializes in treating inpatients and who may coordinate a Participant's health care when the Participant has been admitted for a Medically Necessary procedure or treatment at a Hospital.

2.35 **Injectable Medication** means 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, intra-articular injection, intracavernous injection or intraocular injection. Prior authorization is required for Injectable Medications.

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

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

2.38 **Medically Necessary** means the use of any appropriate medical treatment, service, equipment and/or supply as provided by a Hospital, Skilled Nursing Facility, Physician or other provider which is necessary for the diagnosis, care and/or treatment of a Participant's illness or injury, and which is:

2.38.01 consistent with the symptom, diagnosis, and treatment of the Participant's condition;

2.38.02 the most appropriate level of supply and/or service for the diagnosis and treatment of the Participant's condition;

2.38.03 in accordance with standards of acceptable community practice;

2.38.04 not primarily intended for the personal comfort or convenience of the Participant, the Participant's family, the Physician or other health care providers;

2.38.05 approved by the appropriate medical body or health care specialty involved as effective, appropriate and essential for the care and treatment of the Participant's condition; and

2.38.06 not Experimental or Investigational.

2.39 **Medical Office** means any outpatient facility or Physician's office.

2.40 **Medical Services** (except as limited or excluded by the Plan) means those professional services of Physicians and other Health Professionals, including medical, surgical, diagnostic, therapeutic and preventive services that are:

2.40.01 generally and customarily provided in the Service Area;

2.40.02 performed, prescribed or directed by Participating Providers; and

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

2.41 **Non-participating Provider** means any Health Professional or group of Health Professionals, Hospital, Medical Office or Other Health Care Facility with whom AvMed has neither made arrangements nor contracted to render the professional health services set forth herein as a Participating Provider.

2.42 **Other Health Care Facility(ies)** means any licensed facility, other than acute care Hospitals and those facilities providing services to ventilator dependent patients, which provides inpatient services such as Skilled Nursing Care, Residential Treatment, and Rehabilitative Services, with which AvMed has contracted or established arrangements for providing these services to Participants.

2.43 **Outpatient Rehabilitation Facility** means an entity, which renders, through providers properly licensed pursuant to Florida law or if applicable, equivalent or similar state laws of another state outpatient physical, speech, occupational, and cardiac rehabilitation therapy for the primary purpose of restoring or improving bodily function impaired or eliminated a condition, and with which AvMed has contracted or made arrangements for the provision of such services. The term Outpatient Rehabilitation Facility, as used herein, shall not include a Hospital, including a general acute care Hospital, or any separately organized unity of a Hospital which provides comprehensive medical rehabilitation inpatient services, or rehabilitation outpatient services, including, but not limited to, a Class III "specialty rehabilitation hospital" as described in Chapter 59A, *Florida Administrative Code*.

2.44 **Partial Hospitalization** means treatment in which an individual receives at least 7 hours of institutional care during a portion of a 24 hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered 'home' for purposes of this definition.

2.45 **Participant** means any Covered Employee or Covered Dependent as described in Sections 2.16 and 2.17 of this SPD.

2.46 **Participating Physician** means any Participating Provider licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes* or if applicable, equivalent or similar state laws of another state.

2.47 **Participating Provider** means any Health Professional (or group of Health Professionals), Hospital, Medical Office or Other Health Care Facility with whom AvMed has made arrangements or contracted to render the professional health services set forth herein, and at times shall be referred to as 'Plan Provider'.

2.48 **Plan** means the City of Sunrise Group Medical Plan sponsored by the Employer to provide covered Medical Services to Participants.

2.49 **Plan Administrator** means City of Sunrise, 10770 W. Oakland Park Blvd., Sunrise, Florida 33351, ATTENTION TO: Risk Management, Telephone: 954-572-2496.

2.50 **Post-Service Claim** means any Claim for benefits under the Plan that is not a Pre-Service Claim.

2.51 **Pre-Service Claim** means any Claim for benefits under the Plan for which (in whole or in part), a Participant must obtain authorization from AvMed in advance of such services being provided to or received by the Participant.

2.52 **Primary Care Physician** means any Participating Physician engaged in family practice, pediatrics, internal medicine, obstetrics/gynecology, or any specialty Physician from time to time designated by AvMed as a 'Primary Care Physician' in AvMed's current list of Physicians and Hospitals.

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

2.54 **Rehabilitation Services** are Health Care Services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapies, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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

2.55.01 was relied upon in making a benefit determination;

2.55.02 was submitted, considered or generated in the course of making a benefit determination, without regard to whether it was relied upon in making the determination;

2.55.03 demonstrates compliance with the Plan's administrative process; and

2.55.04 constitutes a statement of policy or guidance with respect to the Plan concerning the Adverse Benefit Determination for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the Adverse Benefit Determination.

2.56 **Residential Treatment** is a 24-hour intensive structured and supervised treatment program providing an inpatient level of care but in a non-Hospital environment, and is utilized for those disorders that cannot be affectively treated in an outpatient or Partial Hospitalization environment.

2.57 **Service Area** means those counties in the State of Florida where AvMed has been approved to conduct business by the Agency for Health Care Administration (AHCA).

2.58 **Skilled Nursing Facility** means an institution or part thereof which is licensed as a Skilled Nursing Facility by the State of Florida, is accredited as a Skilled Nursing Facility by the Joint Commission or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, and with which AvMed has made arrangements or contracted for the provision of appropriate services.

2.59 **Sound Natural Tooth** means a tooth that is whole or properly restored (restoration with amalgams only) and is not in need of the treatment provided for any reason other than an Accidental Dental Injury. For purposes of this Plan, a tooth previously restored with a crown inlay, onlay or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.

2.60 **Specialty Health Care Physician** means any Participating Physician licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes*, (or if applicable, equivalent or similar state laws of another state), other than the Participant's Primary Care Physician.

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

2.62 **Urgent Care Center** means a facility properly licensed to provide care for minor injuries and illnesses that require immediate attention, but are not severe enough for a trip to the emergency room, including cuts, sprains, eye injuries, colds, flu, fever, insect bites, and simple fractures. For purposes of this contract, an Urgent Care Center is not a Hospital, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

2.63 **Urgent Care Claim** means any Claim for medical care or treatment that could seriously jeopardize the Participant's life or health or the Participant's ability to regain maximum function or, in the opinion of a Physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment requested. Generally, the determination of whether a Claim is an Urgent Care Claim shall be made by an individual acting on behalf of AvMed applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. However, if a Physician with knowledge of the Participant's medical condition determines that the Claim is an Urgent Care Claim, it shall be deemed as such.

2.64 **Urgent Medical Condition** means a medical condition manifesting itself by acute symptoms that are of lesser severity than that recognized for an Emergency Medical Condition, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the illness or

injury to place the health or safety of the Participant or another individual in serious jeopardy, in the absence of medical treatment within 24 hours. Examples of Urgent Medical Conditions include, but are not limited to: high fever, dizziness, animal bites, sprains, severe pain, respiratory ailments and infectious illnesses.

2.65 **Urgent Medical Services and Care** means medical screening, examination and evaluation in an ambulatory setting outside of a Hospital emergency department, including an Urgent Care Center, retail clinic or PCP office after-hours, on a walk-in basis and usually without a scheduled appointment; and the covered services for those conditions which, although not life-threatening, could result in serious injury or disability if left untreated.

2.66 **Utilization Management Program** means those comprehensive initiatives that are designed to validate medical appropriateness and to coordinate covered services and supplies. These include, but are not limited to:

2.66.01 concurrent review of all patients hospitalized in acute care, psychiatric, rehabilitation, and skilled nursing facilities, including on-site review when appropriate;

2.66.02 case management and discharge planning for all inpatients and those requiring continued care in an alternative setting (such as home care or a Skilled Nursing Facility) and for outpatients when deemed appropriate; and

2.66.03 the Benefit Coordination Program which is designed to conduct prospective reviews for select medical services to ensure that services are covered and Medically Necessary. The Benefit Coordination Program may also advocate alternative cost-effective settings for the delivery of prescribed care and may identify other options for non-covered health care needs.

2.67 **Ventilator Dependent Care Unit** means care received in any facility which provides services to ventilator dependent patients other than acute Hospital care, including all types of facilities known as sub-acute care units, ventilator dependent units, alternative care units, sub-acute care centers and all other like facilities, whether maintained in a free standing facility or maintained in a Hospital or skilled nursing facility setting.

III. ELIGIBILITY

3.01 To be eligible to enroll as a Covered Employee, a person must be:

3.01.01 an employee of the City of Sunrise who works the required number of hours per week, and is employed for the waiting period required for eligibility, or a retiree.

3.01.02 entitled on his own behalf to participate in the medical and Hospital care benefits provided by the City of Sunrise under the Plan. Coverage begins the first day of the month following the waiting period.

3.02 To be eligible to enroll as a Covered Dependent, a person must be:

3.02.01 the spouse of the Covered Employee (a new spouse must be enrolled within 31 days after marriage in order to be covered); or

3.02.02 a child of the Covered Employee, or a child of a Covered Dependent of the Covered Employee, provided that all of the following conditions apply:

a. The child is under the age of 26; and

b. The natural child or stepchild of the Covered Employee; or

c. A legally adopted child in the custody of the Covered Employee from the time of placement in the home (written evidence of adoption must be furnished to the Employer upon request); or

d. A child for whom the Covered Employee has been appointed legal guardian pursuant to a valid court order. In the event an eligible Dependent child does not reside with the Subscriber, coverage will be extended where the Subscriber if obligated to provide medical care by Qualified Medical Child Support Order (QMCSO). You (or your beneficiaries) may obtain, without charge, copies of the Plan's procedures governing QMCSOs and a sample QMCSO by contacting the Plan Administrator; or

e. The newborn child of a Covered Dependent of the Covered Employee other than the spouse of the Covered Employee (such coverage terminates 18 months after the birth of the newborn child).

With respect to 3.02.02 (a), coverage for a child of a Covered Employee will end at the end of the month in which they reach the age 26. Children up to age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer.

3.02.03 In the case of a newborn child, the Covered Employee should notify the Employer of the intention to enroll the newborn child, and provide any documentation as may be required, not later than 31 days after the birth. If timely notice is provided, no additional premium will be charged for the additional coverage of the newborn during the 31-day period following the birth of the child. If timely notice is not provided, the additional premium for the additional coverage of the newborn child will be charged from the child's date of birth. If notice is not provided within 60 days of the birth, the child may not be enrolled until the next open enrollment period of the Plan.

3.02.04 All services applicable for Covered Dependent children under the Plan shall be provided to an enrolled newborn child of the Covered Employee; to the enrolled newborn child of a Covered Dependent of the Covered Employee; or to the newborn adopted child of the Covered Employee, provided that a written agreement to adopt such child has been entered into (prior to the birth of the child) from the moment of birth (as provided in Section8.22). In the case of the newborn adopted child, coverage shall not be effective if the child is not ultimately placed in the Covered Employee's residence, in compliance with Florida law.

3.02.05 In the event the Covered Employee has a child who meets the following requirements, extended coverage may be available for that child until the end of the Calendar Year in which the child reaches age 30:

a. The child is unmarried and does not have a Dependent of his or her own;

b. The child is a resident of Florida or a Full-Time or Part-Time Student; and

c. The child is not provided coverage as a named Participant, insured, or enrollee under any other group, blanket or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

3.02.06 It is the Participant's responsibility to notify the Employer when the child no longer meets the eligibility requirements of Section 3.02. Termination of coverage may be retroactively applied if the Employer is not notified within 31 days. Participant agrees to provide supporting documentation upon request by AvMed or Employer

3.02.07 No person is eligible to enroll hereunder who has had his coverage previously terminated under Section 7.01.03, except with the written approval of AvMed.

3.02.08 Attainment of the limiting age by a Dependent child shall not operate to exclude from or terminate the coverage of such child, while such child is and continues to be both:

a. incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

b. chiefly dependent upon the Participant for support and maintenance, provided proof of such incapacity and dependency is furnished to the Employer by the Participant within 31 days of the child's attainment of the limiting age, and subsequently as may be required by the Employer, but not more frequently than annually after the 2-year period following the child's attainment of the limiting age.

3.03 During the Contract Year, no changes in the Plan's eligibility or requirements of participation shall be permitted to effect eligibility or enrollment under the Plan unless such change is required by law or agreed to by AvMed.

3.04 If the child of a Covered Employee is enrolled in the Plan on the basis of being a student at a postsecondary educational institution immediately before the first day of a medically necessary leave of absence, the Plan will not terminate the coverage of such child before the earlier of (1) one year after the first day of the medically necessary leave of absence, or (2) the date on which such coverage would otherwise terminate under the terms of the Plan. A "medically necessary leave of absence" is a leave of absence (or any other change in enrollment), from a postsecondary educational institution that (1) begins while the child is suffering from a severe illness or injury, (2) is medically necessary, and (3) causes the child to lose student status under the terms of the Plan. Certification by the child's Attending Physician must be submitted to the Plan stating that the child is suffering from a severe illness or injury and that the leave of absence or other change of enrollment is medically necessary. A child whose benefits are continued under this provision is entitled to the same benefits as if (during the medically necessary leave of absence) the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

IV. ENROLLMENT

4.01 Prior to the effective date of the Plan and at a proper time prior to each anniversary thereof, the Employer may allow an open enrollment period of 31 days in which any eligible employee on behalf of himself and his eligible Dependents may elect to enroll in the Plan.

4.02 Except as provided for newborns, eligible employees and Dependents who meet the eligibility requirements of Section III (ELIGIBILITY) outside of the annual open enrollment period and who qualify for a special enrollment period pursuant to Section 4.03, must enroll within 31 days after becoming eligible by submitting application forms acceptable to or provided by AvMed; otherwise, the eligible employees and Dependents may not enroll until the next open enrollment period of the Employer.

4.03 Special enrollment periods. Eligible employees and their eligible Dependents may request to enroll in the Plan outside of the initial enrollment period and annual open enrollment periods if that individual loses other coverage or acquires a new Dependent as outlined below.

4.03.01 If the eligible employee or Dependent declined coverage under the Plan when it was first offered because of other group medical plan or insurance coverage, and such other coverage has terminated as a result of:

a. exhaustion of COBRA continuation coverage;

b. termination of employment or reduction in hours of employment;

c. termination of employer contributions;

d. legal separation, divorce or annulment;

e. change in Dependent status;

f. death of the employee;

g. change in legal custody or legal guardianship; or

h. relocation out of an HMO service area.

4.03.02 If the eligible or Covered Employee acquires a new Dependent as a result of:

a. marriage;

b. birth; or

c. adoption or placement for adoption.

4.03.03 In the event of 4.03.01 or 4.03.02 above, a completed Enrollment or Status Change Form (together with proof of the qualifying event under 4.03.01) must be submitted within 31 days of the date of termination of other coverage; or within 31 days of the date the Dependent becomes eligible; or within 60 days as required for newborns. To enroll an eligible Dependent, the eligible employee must also enroll or already be a Participant.

4.03.04 Eligible employees and Dependents who are not enrolled, shall be eligible to enroll for coverage within 60 days following:

a. termination of coverage under Medicaid or Children's Health Insurance Plan (CHIP) due to loss of eligibility; or

b. determination of eligibility for premium assistance under Medicaid or CHIP.

c. A completed Enrollment or Status Change Form must be submitted within 60 days of the date of the termination of Medicaid or CHIP coverage; or within 60 days of the date of determination of eligibility for premium assistance under Medicaid or CHIP. To enroll an eligible Dependent, the eligible employee must also enroll or already be a Participant.

4.03.05 Termination resulting from failure to pay premiums on a timely basis or termination of coverage for cause (due to fraud, intentional misrepresentation, etc.) will not provide a special enrollment period.

4.04 The eligibility requirements set forth in Section III (ELIGIBILITY) shall at all times control and no coverage contrary thereto shall be effective. Coverage shall not be implied due to clerical or administrative errors if such coverage would be contrary to Section III (ELIGIBILITY).

V. EFFECTIVE DATE OF COVERAGE

5.01 Subject to the payment of applicable monthly administrative fees, coverage under this Plan shall become effective on the following dates:

5.01.01 Eligible employees and their eligible Dependents that enroll during the open enrollment period will become Participants as of the effective date of this Plan or subsequent anniversary thereof.

5.01.02 If a Participant acquires an eligible Dependent through birth, adoption, placement for adoption or marriage, such Dependent shall be treated as covered under the Plan if, within 31 days (or 60 days as provided for newborns in Section III (ELIGIBILITY) of acquiring the new Dependent, the Participant completes and submits an enrollment form on behalf of such Dependent. If the enrollment form is received by the Employer within the 31 day time period (or 60 days as provided for newborns), the enrollment for such Dependent shall become effective on the date of the birth, adoption or placement for adoption; or in the case of marriage, on the date of marriage. During this period, eligible employees and their eligible Dependents may also enroll for medical coverage under the Plan, if not already covered. However, if an enrollment request is not received by the Employer within the

required time frame, the employee and Dependents will be required to wait until the next open enrollment period to apply for coverage.

5.01.03 Coverage for the newborn child of a Covered Employee or the newborn child of a Covered Dependent is effective at birth if Sections 3.02.03 and 5.01.02 are complied with.

5.01.04 If an eligible employee or the employee's eligible Dependents originally declined medical coverage under the Plan due to other health coverage, and that coverage is subsequently terminated as a result of either a loss of eligibility for such coverage or the termination of any employer contributions for such coverage, or termination of the Plan, the employee and the employee's Dependents will be eligible to enroll in the Plan. To enroll, a completed Enrollment Form must be submitted within 31 days of the date of termination of other coverage. The effective date of any coverage provided under the Plan will be the day following the loss of other coverage. If the employee fails to enroll within 31 days after the loss of other coverage, the employee and the employee's Dependents must wait until the next open enrollment period to apply for coverage, absent eligibility for a second special enrollment period.

5.01.05 If an employee or the employee's Dependents are eligible for coverage but not enrolled, and experience a termination of coverage under Medicaid or CHIP due to loss of eligibility, or are determined to be eligible for premium assistance under Medicaid or CHIP, the employee and the employee's Dependents will be eligible to enroll in the Plan. To enroll, a completed Enrollment Form must be submitted within 60 days of the date of the termination of coverage or the determination of eligibility for assistance. The effective date of any coverage provided by AvMed will be the first day of the month following the date of enrollment. If the employee fails to enroll within 60 days after the loss of such coverage or the determination of such eligibility, the employee and the employee's Dependents must wait until the next open enrollment period to apply for coverage, absent eligibility for a second special enrollment period.

VI. MONTHLY PAYMENTS AND COPAYMENTS

6.01 **Annual maximum out-of-pocket limits** (as described in your Schedule of Benefits). The Coinsurance and Copayments you pay for covered benefits received during any Calendar Year are accumulated toward your annual maximum out-of-pocket limit. Amounts paid as penalties do not count toward any out-of-pocket limits. Once you meet your individual or family annual maximum out-of-pocket limit in any Calendar Year, the Plan will pay 100% of the allowable charges for all covered services for the remainder of that Calendar Year. It is the responsibility of the Participant to retain receipts and to notify and document to the satisfaction of the Plan when the annual maximum out-of-pocket limits have been reached.

Expenses that do not count toward the annual maximum out-of-pocket expense limit are (i) expenses related to charges for services not covered including charges exceeding the Maximum Allowable Payment, (ii) additional charges incurred for failure to pre-authorize a service requiring prior authorization, (iii) expenses that relate to services that exceed any specific treatment Limitations noted in the Schedule of Benefits, and (iv) Brand Additional Charges for Prescription Medications.

6.02 A Participant will be entitled to covered benefits after the Participant has satisfied the amount specified on the Schedule of Benefits. The Participant must pay any applicable Copayments or Coinsurance for covered benefits. Covered benefits that apply are shown in the Schedule of Benefits.

6.03 In the event of the retroactive termination of a Participant, neither the Plan nor AvMed shall be responsible for medical expenses incurred by the Plan in providing benefits to the Participant under the terms of the Plan after the effective date of termination.

VII. TERMINATION OF PARTICIPATION

7.01 **Reasons for Termination**

7.01.01 **Loss of eligibility**

a. Upon the loss of a Participant's eligibility, as defined in Section III (ELIGIBILITY), coverage will either (i) terminate immediately, if AvMed and/or the Employer so elects, in their sole discretion, or (ii) automatically terminate on the last day of the month for which the monthly administrative fee was paid and during which the Participant was eligible for coverage if no election is made under (i) above.

b. Upon a loss of the Covered Employee's eligibility, as defined in Section III (ELIGIBILITY), coverage for all Covered Dependents will either (i) terminate immediately if AvMed and/or the Employer so elects, in their sole discretion, or (ii) automatically terminate on the last day of the month during which the Covered Dependent was eligible for coverage if no election is made under (i) above.

7.01.02 **Failure to pay Copayments and fees**

a. Upon failure of the Employer to make payment of the monthly administrative fee within 30 days following the due date specified by AvMed, benefits under the Plan shall terminate for all Participants for whom such payment has not been received at 12:00 am (midnight) on the last day of the month for which the monthly administrative fee was paid.

b. Upon failure of a Covered Employee to make payment of any contributions or applicable supplemental charges required under Section VI (MONTHLY PAYMENTS AND COPAYMENTS), the Employer and AvMed reserve the right to terminate coverage for the Covered Employee and all Covered Dependents on the tenth day after written notice from AvMed or the Plan.

7.01.03 **Termination of participation for cause**. AvMed may terminate or cease to provide services to any Participant immediately upon written notice for the following reasons which lead to a loss of eligibility of the Participant:

a. Fraud, material misrepresentation or omission in applying for participation, benefits or coverage under the Plan. However, relative to a misstatement in the Application, after two years from the issue date, only fraudulent misstatements in the Application may be used to void the policy or deny any claim for a loss occurred or disability starting after the two year period;

b. Misuse of the Plan's identification card furnished to the Participant;

c. Furnishing to the Plan or AvMed incorrect or incomplete information for the purpose of obtaining participation, coverage or benefits under the Plan; or

d. Behavior which is disruptive, unruly, abusive or uncooperative to the extent that the Participant's continuing coverage under the Plan seriously impairs AvMed's ability to administer the Plan or to arrange for the delivery of health care services to the Participant or other Participants after AvMed has attempted to resolve the Participant's problem.

e. At the effective date of such termination, administrative service fee payments received by AvMed on account of such termination shall be refunded on a pro rata basis, and AvMed shall have no further liability or responsibility for the Participant(s) under the Plan.

7.02 **Notification requirements**:

7.02.01 **Loss of eligibility of Covered Employee**. It is the responsibility of the Employer to notify AvMed in writing within 31 days from the effective date of termination regarding any Covered Employee and/or Covered Dependent who becomes ineligible to participate in the Plan. Employer shall be liable for claims incurred by Covered Employees or Covered Dependents resulting from failure of Employer to provide such timely notification.

7.02.02 **Loss of eligibility of Covered Dependent**. When a Covered Dependent becomes ineligible for coverage, the Covered Employee is required to notify the Plan Administrator in writing within 31 days of the Covered Dependent becoming ineligible.

7.03 **Continuation Coverage under COBRA**. COBRA requires that most employers sponsoring group health plans offer certain employees and former employees their eligible Dependents the opportunity for a temporary extension of health coverage (called 'continuation coverage') at group rates in certain instances where coverage under the Plan would otherwise end. This section of the SPD is intended to inform Participants, in a summary fashion, of their rights and obligations under the continuation coverage provisions of the law. Participants should take the time to read this section carefully.

7.03.01 **Eligibility**. Covered Employees or their Covered Dependents will become eligible for continuation coverage under COBRA after any of the following qualifying events result in the loss of Plan coverage:

a. Loss of benefits due to a reduction in the Covered Employee's hours of employment;

b. Termination of the Covered Employee's employment including retirement but excluding termination for gross misconduct; or

c. Termination of employment following leave under the Family and Medical Leave Act of 1993 (FMLA), in which case the qualifying event will occur on the earlier of the date the Covered Employee indicates he will not return to work or the last day of the FMLA leave.

d. In addition, Covered Dependents will become eligible for COBRA continuation coverage after any of the following qualifying events occur to cause a loss of Plan coverage:

i. The Covered Employee's death;

ii. Divorce, legal separation from the Covered Employee;

iii. The Covered Employee first becomes entitled to and enrolls in Medicare; or

iv. The Covered Dependent child no longer qualifies as an eligible Dependent under the Plan.

e. A child who is born to (or placed for adoption) with a covered former employee during the continuation coverage period has the same continuation coverage rights as an eligible Dependent child described above.

7.03.02 **Notification**. If a qualifying event other than divorce, legal separation, loss of eligible Dependent status or entitlement to Medicare occurs, the Employer will notify AvMed and its COBRA Administration business partner, of the qualifying event, who will send the Covered Employee an election form. To continue Plan coverage, the completed election form must be returned to AvMed's COBRA Administrator business partner within 60 days after the date the form is received, or the date the Covered Employee's coverage ends due to the qualifying event.

a. If divorce, legal separation, loss of eligible Dependent status or entitlement to Medicare under the Plan occurs, the Covered Employee or Covered Dependent is responsible for notifying the Plan Administrator that a qualifying event has occurred. Such notice must be received by the Plan Administrator within 60 days after the later of the date of such event, or the date the Participant would lose coverage on account of such event. Failure to timely notify the Plan Administrator of these events will result in loss of the right of a Participant to continue coverage.

b. After receiving such notice, the Plan Administrator will notify AvMed and its COBRA Administration business partner, who will send the Participant an election form within 14 days. If the Participant wishes to elect continuation coverage, the election form must be returned completed to the AvMed's COBRA Administration business partner within 60 days from the later of the date the form is received or the date coverage ends due to the qualifying event.

7.03.03 **Cost**. If continuation coverage is elected, Participants must pay the entire cost of coverage (the employer's contribution and the active employee portion of the contribution), plus a 2% administrative fee for the duration of COBRA continuation coverage.

a. If a Covered Employee or Covered Dependent is Social Security disabled (Social Security disability status must occur as defined by Title II or Title XVI of the Social Security Act), the Covered Employee may elect continuation coverage for the disabled person only or for some or all COBRA eligible family members for up to 29 months if the Covered Employee's employment is terminated or hours are reduced. The Covered Employee must pay 102% of the cost of coverage for the first 18 months of COBRA continuation coverage and 150% of the cost of coverage for the 19th through the 29th months of coverage. The Social Security disability date must be determined to have occurred within the first 60 days of loss of coverage due to termination of the Covered Employee's employment or reduction in hours.

b. For COBRA coverage to remain in effect, payment must be received by the Plan Administrator by the first day of the month for which the premium is due (the first payment is due no later than 45 days after the election to continue coverage, and must cover the period of time back to the first day of COBRA continuation coverage).

7.03.04 **Duration**. COBRA Continuation Coverage can be continued for up to:

a. **18 months** if coverage ended due to a reduction in a Covered Employee's work hours or termination of employment and the Covered Employee or one of his Covered Dependents is not Social Security disabled within 60 days of the date of the loss of coverage due to termination of employment or reduction in hours. If the Covered Employee becomes entitled to Medicare during the course of this initial 18 months of coverage, the Covered Dependents may elect to extend COBRA for an additional 18 months; or

b. **36 months** for Covered Dependents, if the Covered Dependents lose eligibility for medical coverage due to the Covered Employee's death, divorce or legal separation from the Covered Employee, the Covered Employee's entitlement to Medicare after termination or reduction in hours, or the Covered Employee's Covered Dependent child ceasing to qualify as an eligible Dependent under the Plan; or

c. **29 months** if the Covered Employee's coverage is lost due to termination of employment or reduction in hours and the Covered Employee or Covered Dependent is disabled, as defined by Title II or Title XVI of the Social Security Act, within 60 days of the original qualifying event. In this case, the Covered Employee may continue

coverage for an additional 11 months after the original 18-month period either for the disabled person only or for one or all of the Covered Dependents.

i. To be eligible for extended coverage due to Social Security disability, a Covered Employee must notify the Plan Administrator of the disability before the end of the initial 18 months of COBRA continuation coverage and within 60 days following the date the Covered Employee or Covered Dependent is determined to be disabled by the Social Security Administration. If the disabled individual should no longer be considered to be disabled by the Social Security Administration, the Covered Employee must notify the Plan Administrator within 30 days following the end of the disability. Coverage that has exceeded the original 18-month continuation period will end when the individual is no longer Social Security disabled.

d. If more than one qualifying event occurs, no more than 36 months total of COBRA continuation coverage will be available. The COBRA beneficiary must experience the second qualifying event during the first 18 months of COBRA continuation, and must provide notice to the Plan Administrator within the required time period. COBRA continuation coverage will end sooner if the Plan terminates and the employer does not provide replacement medical coverage, or if a person covered under COBRA:

i. first becomes covered under another group health plan after the loss of coverage due to a termination or reduction in hours, this Plan will be secondary for all eligible health care expenses, provided contributions for COBRA coverage continue to be paid. Coverage may only continue for the remainder of the original COBRA period;

ii. fails to make required contributions when due;

iii. first becomes entitled to Medicare benefits after the initial COBRA qualifying event; or

iv. is extending the 18-month coverage period because of disability and is no longer disabled as defined by the Social Security Act.

7.04 **Continuation Coverage during leaves of absence**.

7.04.01 **Family and Medical Leaves of Absence (FMLA)**. Under FMLA, a Covered Employee may be entitled to up to a total of 12 weeks of unpaid job-protected leave during each Calendar Year for the following:

a. the birth of the Covered Employee's child, to care for the newborn child, or for placement of a child in the Covered Employee's home for adoption or foster care;

b. to care for a spouse, child or parent with a serious health condition; or

c. for the Covered Employee's own serious health condition.

d. If the FMLA leave is paid, such pay will be reduced by the amount of the Covered Employee's before-tax contributions as usual for the coverage level in effect on the date FMLA leave begins. If FMLA leave is unpaid, the Covered Employee will be required to pay contributions directly to the employer until returning to active pay status.

e. If the Covered Employee notifies the employer that he is terminating employment during FMLA leave, coverage will end on the date of notification. If the Covered Employee does not return to work on the expected FMLA return date, and the employer is not notified of the intent either to terminate employment or to extend the period of leave, coverage will end on the date the Covered Employee was expected to return.

f. Plan elections may not be changed during FMLA leave unless an open enrollment occurs or the Covered Employee has a change in status event or a special enrollment event under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

7.04.02 **Military leaves of absence**. If a Covered Employee is absent from work due to military service, continuation coverage under the Plan (including coverage for enrolled Dependents) may be elected for up to 18 months from the first day of absence (or if earlier, until the day after the date the Covered Employee is required to apply for or return to active employment with the employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). The Covered Employee's contributions for continued coverage will be the same as for similarly situated active participants in the Plan.

a. Whether or not coverage is continued during military service, a Covered Employee may reinstate coverage under the Plan option elected on return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that any required waiting period was not completed prior to the start of the military service.

VIII. SCHEDULE OF BASIC BENEFITS

AvMed is committed to arranging for comprehensive prepaid health care services rendered to Participants through AvMed's network of contracted independent Physicians and Hospitals and other independent health care providers, under reasonable standards of quality health care. The professional judgment of a Physician licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes*, or if applicable, equivalent or similar laws of another state, concerning the proper course of treatment for a Participant shall not be subject to modification by AvMed or its Board of Directors, Officers or Administrators. However, this Section is not intended to and shall not restrict any Utilization Management Program established by AvMed.

Only services and benefits in conformity with Section II (DEFINITIONS), Section VIII (SCHEDULE OF BASIC BENEFITS), Section IX (LIMITATIONS OF BASIC BENEFITS), Section X (EXCLUSIONS FROM BASIC BENEFITS) and the Schedule of Benefits, which by reference is incorporated herein, are covered by the Plan. It is the Participant's responsibility when seeking benefits under the Plan to identify himself as a Plan Participant and to assure that the services received by the Participant are being rendered by Participating Providers. Participants must understand that services will not be covered if they are not, in AvMed's opinion, Medically Necessary. Any and all decisions made by AvMed in administering the provisions of this Contract, including without limitation, the provisions of Section VIII (SCHEDULE OF BASIC BENEFITS), Section IX (LIMITATIONS OF BASIC BENEFITS) and Section X (EXCLUSIONS FROM BASIC BENEFITS) are made only to determine whether payment for any benefits will be made by the Plan.

Any and all decisions that pertain to the medical need for, or desirability of, the provision or non-provision of Medical Services or benefits, including without limitation, the most appropriate level of such Medical Services or benefits, must be made solely by the Participant and his Physician in accordance with the normal patient/Physician relationship for purposes of determining what is in the best interest of the Participant. AvMed does not have the right of control over the medical decisions made by the Participant's Physician or health care providers. The ordering of a service by a Physician, whether participating or non-participating, does not in itself make such service Medically Necessary. The Employer and Participants acknowledge that it is possible that a Participant and his Physician may determine that such services or supplies are appropriate even though such services or supplies are not covered and will not be arranged or paid for by the Plan. Any covered service for which the Participant is seeking reimbursement, must be submitted to AvMed within one year from the date of service to be considered.

Cost-Sharing Information

Participants should remember that services that are provided or received without advance authorization from AvMed, or when the service is beyond the scope of practice authorized for that provider under State law, are not covered unless such services otherwise have been expressly authorized under the terms of the Plan or when required to treat an Emergency Medical Condition. Except for Emergency Medical Services and Care, all services must be received from Participating Providers. Any Participant requiring medical, Hospital or ambulance services for emergencies (as described in Sections 2.20 and 2.21), either while temporarily outside the Service Area or within the Service Area but before they can reach a Participating Provider, may receive the emergency benefits as specified in Section 8.12.

Prior authorization of Covered Services

Services that require prior authorization from AvMed include, but are not limited to:

- All non-emergency inpatient admissions (including but not limited to Hospital and observation stays, skilled nursing facilities, ventilator dependent care and/or acute rehabilitation);
- All Home Health Care Services
- Complex diagnostic testing, therapeutic, and sub-specialty procedures (including but not limited to CT, CTA, MRI, MRA, PET Scans, Nuclear Cardiac Studies, Nuclear Medicine, and Radiation Oncology);
- Surgical procedures or services performed in an outpatient Hospital, Hospital-affiliated ambulatory surgery center
- All medications administered in an outpatient Hospital or infusion therapy setting
- Select medications administered in a Physician's office
- Care rendered by Non-participating Providers (except for Emergency Medical Services and Care)
- Transplant services
- Dialysis services

Services requiring prior authorization may change from time to time. For more information about which services require prior authorization, contact AvMed at 1-844-263-2369, or visit www.avmed.org.

Within the Service Area, Participants are entitled to receive the covered services and benefits only as herein specified and appropriately prescribed or directed by Participating Physicians. The covered services and benefits listed in Section VIII (SCHEDULE OF BASIC BENEFITS), are available only from Participating Providers within the Service Area and, except for Emergency Medical Services and Care as provided in Section 8.12, the Plan shall have no liability or obligation whatsoever on account of services or benefits sought or received by any Participant from any Non-participating Provider or other person, institution or organization, unless prior arrangements have been made for the Participant and confirmed by written referral or authorization from AvMed.

AvMed encourages but does not require Participants to select a Primary Care Physician (PCP) upon enrollment. For children, Participants may designate a pediatrician as the PCP. Participants have the right to designate any PCP who participates in our network and who is available to accept you or your family members. Until you make this designation, AvMed may designate one for you. For information on how to select a PCP, and for a list of the participating PCPs, contact AvMed. The names and addresses of Participating Providers and Hospitals are set forth in a separate booklet which, by reference, is made a part hereof. The list of Participating Providers, which may change from time to time, will be provided to the Employer. The list of Participating Providers may also be accessed from the AvMed Website at www.avmed.org. Notwithstanding the printed booklet, the names and addresses of Participating Providers on file with AvMed at any given time shall constitute the official and controlling list of Participating Providers.

The selection of a PCP can be changed at any time. Health Professionals may from time to time cease their affiliation with AvMed. In such cases, Participants will be required to receive services from another participating Health Professional, subject to continuity of care rules to the extent required by law.

If a Participant does not follow the access rules, he risks having the services and supplies received not covered under the Plan. In such a circumstance, any payment that AvMed may make will not exceed the Maximum

Allowable Payment and the Participant will be responsible for reimbursing AvMed any Maximum Allowable Payment made for the services and supplies received.

PARTICIPANTS ARE RESPONSIBLE AND WILL BE LIABLE FOR COPAYMENTS AND COINSURANCE WHICH MUST BE PAID TO HEALTH CARE PROVIDERS FOR CERTAIN SERVICES, AT THE TIME SERVICES ARE RENDERED, AS SET FORTH IN THE SCHEDULE OF BENEFITS. THE SCHEDULE OF BENEFITS IS A SEPARATE DOCUMENT AVAILABLE FROM THE PLAN ADMINISTRATOR OR AVMED'S MEMBER SERVICES AND IS INTENDED TO ACCOMPANY THIS SPD IN EXPLAINING THE BENEFITS AVAILABLE UNDER THE PLAN.

8.01 **Ambulance services** as follows:

8.01.01 Local professional air/ground ambulance transport for emergency services to the nearest emergency department appropriately staffed and equipped to treat a medical condition;

8.01.02 Ground transportation to an alternative level of care when associated with an approved Hospital confinement; and

8.01.03 Ground transportation to a Participant's home will be covered when associated with an approved hospitalization or other confinement and the Participant's condition requires the skill of medically trained personnel. Transportation is not covered when the skill of medically trained personnel is not required and the Participant can be safely transferred (or transported) by other means.

8.01.04 Air ambulance transportation is covered only when the point of pick-up is inaccessible by land or when distance or other obstacles are involved in transporting the Participant to the nearest emergency department equipped to adequately treat the medical condition.

8.02 **Cardiac rehabilitation**. Cardiac rehabilitation is covered for the following conditions: acute myocardial infarction, percutaneous transluminal coronary angioplasty (PTCA), coronary artery bypass graft (CABG), repair or replacement of heart valves or heart transplant. Coverage is limited to a maximum of 18 visits per Calendar Year.

8.03 **Clinical trials.** Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

8.03.01 cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

8.03.02 cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as AvMed determine, a clinical trial meets the qualifying clinical trial criteria stated below.

8.03.03 Surgical musculoskeletal disorders of the spine, hip and knees, which are not life-threatening, for which AvMed determines a clinical trial meets the qualifying clinical trial criteria stated below.

8.03.04 Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial. Benefits are available only when the Participant is clinically eligible for participation in the qualifying clinical trial as defined by the researcher. Participants are required to use a Participating Provider for any clinical trials covered under this Summary Plan Description.

8.03.05 Routine patient care costs for qualifying clinical trials include:

a. Covered Health Services for which benefits are typically provided absent a clinical trial;

b. Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications;

c. Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

8.03.06 Routine costs for clinical trials do not include:

a. The Experimental or Investigational service or item. The only exceptions to this are:

i. certain Category B devices;

ii. certain promising interventions for patients with terminal illnesses;

iii. other items and services that meet specified criteria in accordance with our medical and drug policies.

b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

d. Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

8.03.07 With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the list below. With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees which are not life threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the list below.

a. Federally funded trials. The study or investigation is approved or funded by (which may include funding through in-kind contributions) by one or more of the following:

i. National Institutes of Health (NIH). (Includes National Cancer Institute.)

ii. Centers for Disease Control and Prevention.

iii. Agency for Healthcare Research and Quality.

iv. Centers for Medicare and Medicaid Services.

v. A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veteran's Administration.

vi. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.

vii. The Department of Veteran Affairs, the DOD, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:

(a) Comparable to the system of peer review of studies and investigations used by the NIH.

(b) Ensures unbiased review of the highest scientific standard by qualified individuals who have no interest in the outcome of the review.

b. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.

c. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

d. The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards before participants are enrolled in the trial. AvMed may, at any time, request documentation about the trial.

e. The subject or purpose of the trial must be the evaluation or an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

8.04 **Coverage for cleft lip and cleft palate** for Participants under 18 years of age. The coverage provided by this Section is subject to the terms and conditions applicable to other benefits.

8.05 **Dermatological services**. AvMed will cover office visits to a participating dermatologist for Medically Necessary covered services subject to Sections 2.38 and 2.66. No prior referral is required for these services.

8.06 **Diabetes treatment** includes all Medically Necessary equipment, supplies, and services to treat diabetes. This includes outpatient self-management training and educational services if the Participant's Primary Care Physician or the Physician to whom the Participant has been referred who specializes in diabetes treatment certifies the equipment, supplies or services are Medically Necessary. Insulin pumps are covered under Section 8.11. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board certified endocrinologist under contract with AvMed.

8.07 **Diabetic supplies**. Insulin, insulin syringes, lancets, and test strips are covered under the supplemental prescription medication benefits.

8.08 **Diagnosis and treatment of Autism Spectrum Disorder** through speech therapy, occupational therapy, physical therapy, and Applied Behavior Analysis services for an individual under 18 years of age or an individual 18 years of age or older who is in high school who has been diagnosed as having a developmental disability at 8 years of age or younger.

8.08.01 Coverage shall be limited to services that are prescribed by the treating Physician in accordance with a treatment plan. The treatment plan required shall include, but is not limited to, a diagnosis, the proposed treatment by type, the frequency and duration of treatment, the anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the treating Physician.

8.09 **Diagnostic imaging and laboratory**. All prescribed diagnostic imaging and laboratory tests and services including diagnostic imaging, fluoroscopy, electrocardiograms, blood and urine and other laboratory tests, and diagnostic clinical isotope services are covered when Medically Necessary and ordered by a Participating Physician as part of the diagnosis and/or treatment of a covered illness or injury or as preventive health care services.

8.10 **Diagnostic testing and treatment related to Attention Deficit Hyperactivity Disorder (ADHD)**. Coverage is subject to applicable Copayments and coverage limitations as outlined on the Schedule of Benefits. Covered services do not include those that are primarily educational or training in nature.

8.11 **Durable Medical Equipment (DME)**. This Plan provides benefits, when Medically Necessary, for the purchase or rental of such DME that:

8.11.01 can withstand repeated use (i.e. could normally be rented and used by successive patients);

8.11.02 is primarily and customarily used to serve a medical purpose;

8.11.03 generally is not useful to a person in the absence of illness or injury; and

8.11.04 is appropriate for use in a patient's home.

8.11.05 Some examples of DME are: hospital beds, crutches, canes, walkers, wheelchairs, oxygen, respiratory equipment, apnea monitors and insulin pumps. It does not include hearing aids or corrective lenses, or the professional fee for fitting same. It also does not include medical supplies and devices, such as a corset, which do not require prescriptions. The Plan will pay for rental of equipment up to the purchase price. Repair and/or replacements are not covered if equipment has been lost, stolen, abused or misused.

8.11.06 Oxygen is covered when Medically Necessary pursuant to AvMed's coverage guidelines, which are available free of charge upon request. The type of oxygen delivery system covered (stationary, portable, ambulatory) is based on the Participant's activity status. Initial coverage is contingent upon arterial blood gas results. Reassessment of oxygen needs through pulse oximetry at rest and after exercise is required and must be performed by an independent respiratory provider at three months after the initiation of therapy and then yearly in order to re-qualify coverage of oxygen therapy.

8.11.07 The determination of whether a covered item will be paid under the DME, orthotics or prosthetics benefits will be based upon its classification as defined by the Centers for Medicare and Medicaid Services.

8.12 **Emergency services**. The Plan will cover all necessary Physician and Hospital Services for Emergency Medical Services and Care. See Sections 2.20 and 2.21. In the event Hospital inpatient services are provided following Emergency Medical Services and Care, AvMed should be notified by the Hospital, Participant or designee, within 24-hours of the inpatient admission if reasonably possible. AvMed may elect to transfer the Participant to a Participating Provider as soon as it is medically appropriate to do so. AvMed will pay the Maximum Allowable Payment to a Non-participating Provider only for those services rendered before a Participant's condition permits him or her to be reasonably able to travel to a participating facility. In addition, any Participant requests for reimbursement (of payment made by the Participant for services rendered) must be filed within 90 days after the emergency, or as soon as reasonably possible, but not later than one year unless the Claimant was legally incapacitated.

8.13 **General anesthesia and hospitalization services to a Participant who is under 8 years of age** and is determined by a licensed dentist and the Participant's Physician to require necessary dental treatment in a Hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or if the Participant has one or more medical conditions that would create significant or undue medical risk for the Participant in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or ambulatory surgical center. Pre-authorization by AvMed is required. There is no coverage for diagnosis or treatment of dental disease.

8.14 **Home Health Care Services (Skilled Home Health Care)**. Home Health Care Services (as defined in Section 2.30) are covered when ordered by and under the direction of the Participant's Attending Physician. Services are limited to a period of two hours or less per visit, and 60 visits per Calendar Year. Rehabilitative physical, occupational or speech therapy services provided in the home are limited as noted in Section 9.10. Home Health Care Services that do not include a medical, diagnostic, therapeutic or rehabilitative component or that do not require the skill of a registered nurse, licensed practical (vocational) nurse or other healthcare personnel are not covered. Homemaker or other Custodial Care services are not covered.

8.15 **Hospital care: inpatient**. All non-emergency Hospital inpatient services received at Participating Hospitals for non-mental illness or injury are provided when prescribed by Participating Physicians and pre-authorized by AvMed. Inpatient services include semi-private room and board, birthing rooms, newborn nursery care, nursing care, meals and special diets when Medically Necessary, use of operating rooms and related facilities, the intensive care unit and services, diagnostic imaging, laboratory and other diagnostic tests, medications, biologicals, anesthesia and oxygen supplies, physical therapy, radiation therapy, respiratory therapy, and administration of blood or blood plasma. See Section 8.12 with regard to inpatient admission following Emergency Medical Services and Care.

8.16 **Hospice services**. Services are available from a participating Hospice organization for a Participant whose Participating Physician has determined the Participant's illness will result in a remaining life span of 18 months or less.

8.17 **Major organ transplants** at a facility deemed appropriate and authorized by AvMed, as well as associated immunosuppressant medications are covered except those deemed Experimental. See Section 10.15. Organ acquisition and donor costs are covered, including complications and pre-transplant services.

8.18 **Mammograms** are covered in accordance with Florida Statutes and the U.S. Preventive Services Task Force (USPSTF) preventive services recommendations (Grade A and B). One baseline mammogram is covered for female Participants between the ages of 35 and 39. A mammogram is available every two years for female Participants between the ages of 40 and 49 and a mammogram is available every year for female Participants aged 50 and older.

8.18.01 In addition, one or more mammograms a year are available when based upon a Physician's recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of 30.

8.19 **Mastectomy surgery**. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Right's Act of 1988 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the Attending Physician and the patient, for:

8.19.01 all stages of reconstruction of the breast on which the mastectomy has been performed;

8.19.02 surgery and reconstruction on the other breast to produce a symmetrical appearance; and

8.19.03 prostheses and physical complications during all stages of mastectomy including lymphedemas.

8.19.04 The length of stay will not be less than that determined by the Attending Physician to be Medically Necessary in accordance with prevailing medical standards and after consultation with the covered patient. The Attending Physician, after consultation with the covered patient, may choose that the outpatient care be provided at the most medically appropriate setting, which may include the Hospital, treating Physician's office, outpatient center or home of the covered patient.

8.19.05 Coverage is subject to the same Copayments applicable to other medical and surgical benefits provided under the Plan, and will require prior authorization of services as applicable to other surgical procedures or hospitalizations under the Plan.

8.19.06 If you would like more information on WHCRA benefits, call AvMed at 1-844-263-2369.

8.20 **Mental Health Services.** Inpatient intermediate and outpatient Mental Health Services are covered when Medically Necessary and may be covered when a Participant is admitted to a Participating Hospital or Other Health Care Facility.

8.20.01 Intermediate Mental Health Services in a Residential Treatment facility may be covered under a 24-hour intensive and structured supervised treatment program providing an inpatient level of care but in a non-Hospital environment, for those disorders that cannot be effectively treated in an outpatient or Partial Hospitalization environment. Prior Authorization is required.

8.20.02 Partial Hospitalization may be covered under a structured program of active psychiatric treatment provided in a Hospital outpatient setting or by a community mental health center, that is more intense than the care received in a Physician's or therapist's office, as an alternative to inpatient hospitalization. Prior Authorization is required.

8.20.03 Outpatient, and intensive outpatient treatment for mental health disorders may be covered when provided by a state-licensed psychiatrist or other Physician, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, Physician assistant, or other qualified mental health professional as allowed under applicable state law.

8.21 **Nutrition Therapy**. Enteral formulas, nutritional supplements and low protein modified foods for use at home by a covered person that are prescribed or ordered by a health care practitioner and are for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU). Coverage shall include food products modified to be low protein for a covered person.

8.22 **Newborn care**. All services applicable for children under the Plan are covered for an enrolled newborn child of the Covered Employee, or the enrolled newborn child of a Covered Dependent of the Covered Employee, or the newborn adopted child of the Covered Employee (as described in Section 3.02.04), from the moment of birth, including the Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, and transportation costs to the nearest facility appropriately staffed and equipped to treat the newborn's condition when such transportation is Medically Necessary. Circumcisions are provided for up to one year from date of birth.

8.23 **Non-participating Provider services**. When, in the professional judgment of AvMed's Medical Director, a Participant needs covered Medical or Hospital Services which require skills or facilities not available from Participating Providers, and it is in the best interest of the Participant to obtain the needed care from a Non-participating Provider, upon authorization by the Medical Director, payment not to exceed the Maximum Allowable Payment will be made for such covered services rendered by a Non-participating Provider. Such covered Medical or Hospital services will be reimbursed in accordance with the covered benefits the Participant would be entitled to receive from a Participating Provider.

8.24 **Obstetrical and gynecological care**. An annual gynecological examination and Medically Necessary follow-up care detected at that visit are available without the need for a prior referral. Participants do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please refer to your provider directory. Obstetrical care benefits as specified herein are covered and include Hospital care, anesthesia, diagnostic imaging and laboratory services for conditions related to pregnancy unless such pregnancy is the result of a preplanned adoption arrangement, more commonly known as surrogacy. The length of maternity stay in a Hospital will be that determined to be Medically Necessary in compliance with Florida law and in accordance with the Newborns' and Mothers' Health Protection Act (NMHPA). Group health plans and health insurance issuers generally may not, under Federal law (including the NMHPA), restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child below certain levels. These levels are as follows:

8.24.01 Hospital stays of at least 48 hours following a normal vaginal delivery, or at least 96 hours following a cesarean section (under Federal law, the Plan may not require that your provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 or 96 hours, as appropriate);

8.24.02 The Attending Physician does not need to obtain authorization from AvMed to prescribe a Hospital stay of this length;

8.24.03 The Plan will cover an extended stay, if Medically Necessary; however, the Physician or Hospital must pre-certify the extended stay.

8.24.04 Shorter Hospital stays are permitted if the Attending Physician, in consultation with the mother, determines that to be best course of action. Coverage for maternity care is subject to applicable Copayments and all other Plan limits and requirements.

8.25 **Orthotic appliances**. Coverage for orthotic appliances is limited to custom-made leg, arm, back and neck braces when related to a surgical procedure or when used in an attempt to avoid surgery and when necessary to carry out normal activities of daily living, excluding sports activities. Coverage includes the initial purchase, fitting or adjustment. Replacements are covered only when Medically Necessary due to a change in bodily configuration. All other orthotic appliances are not covered. The determination of whether a covered item will be paid under the DME, orthotics or prosthetics benefits will be based upon its classification as defined by the Centers for Medicare and Medicaid Services.

8.26 **Osteoporosis diagnosis and treatment** when Medically Necessary for high-risk individuals, including but not limited to, estrogen-deficient individuals, individuals with vertebral abnormalities, individuals on long-term glucocorticoid (steroid) therapy, individuals with primary hyperparathyroidism and individuals with a family history of osteoporosis.

8.27 **Other Health Care Facility(ies)**. All routine services of Other Health Care Facilities (see Section 2.42), including Physician visits, physiotherapy, diagnostic imaging and laboratory work, are covered when a Participant is admitted to such a facility, following discharge from a Hospital, for a condition that cannot be adequately treated with Skilled Home Health Care Services or on an ambulatory basis.

8.28 **Outpatient therapeutic services**. Covered health services for therapeutic treatments received on an outpatient basis in the home, Physician's office, Other Health Care Facility or Hospital, including intravenous chemotherapy or other intravenous infusion therapy and Injectable Medications. Self-Administered Injectable Medications are only a covered benefit when included in the supplemental prescription medication benefits.

8.29 **Physical, occupational or speech therapy**. Short-term rehabilitative physical, occupational and speech therapy provided in an outpatient or home care setting is covered to improve or restore physical functioning following disease, injury or loss of a body part. Habilitative physical, occupational and speech therapy provided in an outpatient or home care setting is covered when provided to help a person keep, learn or improve skills and functioning for daily living. Spinal manipulations/adjustments will be covered when performed in a health care practitioner's office, or in rehabilitation facility on an inpatient or outpatient basis. Clinical documentation or a treatment plan to support the need for therapy services or continuing therapy must be submitted for review. Please refer to your Schedule of Benefits for applicable benefit maximums and Limitations.

8.29.01 Continued therapy is only Medically Necessary when this care is prescribed by a Participating Physician in order to significantly improve, develop or restore physical functions that have been lost or impaired. Using additional diagnoses to obtain additional therapy for the same condition is not considered Medically Necessary. Once maximum therapeutic benefit has been achieved, and there is no longer any progression, or a home exercise program could be used for any further gains, continuing supervised therapy is not considered Medically Necessary. Therapy in persons whose condition is neither regressing

nor improving is considered not Medically Necessary. Therapy in asymptomatic persons or in persons without an identifiable clinical condition is considered not Medically Necessary.

8.29.02 Additional therapy can be considered for a new or separate condition in a person who previously received therapy for another indication. An exacerbation or flare-up of a chronic illness is not considered a new incident of illness.

8.29.03 Home-Based Physical Therapy is Medically Necessary in selected cases based upon the Member's needs i.e., the Member must be homebound. This may be considered Medically Necessary in the transition of the Member from Hospital to home, and may be an extension of case management services.

8.29.04 Non-covered services include:

a. Services that involve non-diagnostic, non-therapeutic, routine, or repetitive procedures to maintain general welfare and do not require the skilled assistance of a licensed therapist.

b. Services such as general exercise programs to promote overall fitness and endurance, for diversion or for general motivation.

c. Other non-covered treatments specifically for Autism and Autism Spectrum disorders unless required by federal or Florida law.

d. Physical therapy modalities that are considered investigational and not covered include, but are not limited to: Interactive Metronome Program, Augmented Soft Tissue Mobilization, Kinesio Taping/Taping, MEDEK Therapy, Hands-Free Ultrasound and Low-Frequency Sound (Infrasound), and Hivamat Therapy (Deep Oscillation Therapy).

8.30 **Physician care: inpatient**. All Medical Services rendered by Participating Physicians and other Health Professionals when requested or directed by the Attending Physician, including surgical procedures, anesthesia, consultation and treatment by Specialty Health Care Physicians, laboratory and diagnostic imaging services, and physical therapy (see Section 8.29) are covered while the Participant is admitted to a Participating Hospital as a registered bed patient. When available and requested by the Participant, the Plan covers the services of a certified nurse anesthetist licensed under Chapter 464, *Florida Statutes*.

8.31 **Physician care: outpatient**

8.31.01 **Diagnosis and treatment**. All Medical Services rendered by Participating Physicians and other Health Professionals, are covered when Medically Necessary and when provided at Medical Offices, including surgical procedures, routine hearing examinations and vision examinations for glasses for children under age 18 (such examinations may be provided by optometrists licensed pursuant to Chapter 463, *Florida Statutes* or by ophthalmologists licensed pursuant to Chapter 458 or 459, *Florida Statutes*), or if applicable, equivalent or similar laws of another state, and consultation and treatment by Specialty Health Care Physicians. Also included are non-reusable materials and surgical supplies. These services and materials are subject to the Limitations outlined in Section IX (LIMITATIONS OF BASIC BENEFITS). See Section X (EXCLUSIONS FROM BASIC BENEFITS).

8.31.02 **Preventive and health maintenance services**. Coverage includes services of Participating Providers for illness prevention and health maintenance, including items or services that have an A or B rating in current recommendations of the U.S. Preventive Services Task Force (USPSTF); immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-informed preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional preventive care and screening (with respect to

women) provided for in guidelines supported by the Health Resources and Services Administration.

8.32 **Prescription medication benefits**. Allergy serums and chemotherapy for cancer patients are covered. Coverage for insulin and other diabetic supplies is described in Section 8.07. Other retail prescription medications are a covered benefit when the Plan includes prescription medication benefits; coverage is subject to the Copayment/Coinsurance provisions outlined therein. See the form entitled Prescription Medication Benefits for a description of other prescription medication coverage.

8.33 **Prosthetic devices**. This Plan provides benefits, when Medically Necessary, for prosthetic devices designed to restore bodily function or replace a physical portion of the body. Coverage for prosthetic devices is limited to artificial limbs, artificial joints, ocular prostheses and cochlear implants. Coverage includes the initial purchase, fitting or adjustment. Replacement is covered only when Medically Necessary due to a change in bodily configuration. The initial prosthetic device following a covered mastectomy is also covered. Replacement of intraocular lenses is covered only if there is a change in prescription that cannot be accommodated by eyeglasses. All other prosthetic devices are not covered, including prosthetic devices for Deluxe, Myo-electric and electronic prosthetic devices. The determination of whether a covered item will be paid under the DME, orthotics or prosthetics benefits will be based upon its classification as defined by the Centers for Medicare and Medicaid Services.

8.34 **Removal of benign skin lesions** including, but not limited to, warts, moles, skin tags, lipomas, keloids and scars are covered.

8.35 **Second medical opinions**. The Participant is entitled to a second medical opinion when he disputes the appropriateness or necessity of a surgical procedure or is subject to a serious injury or illness.

8.35.01 The Participant may obtain a second medical opinion from any Physician who is within AvMed's Service Area. If a Participating Physician is chosen, there is no prior authorization requirement. The Participant pays only the applicable Copayment. If a non-participating Physician is chosen, the service is subject to prior authorization requirements. The Participant is also responsible for 40% of the amount of the Maximum Allowable Payment associated with the consultation.

8.35.02 Any tests that may be required to render the second medical opinion must be arranged by AvMed and performed by Participating Providers. Once a second medical opinion has been rendered, AvMed shall review and determine the treatment obligations of the Plan, and that judgment is controlling, subject to the Plan's appeals process. Any treatment the Participant obtains that is not authorized by AvMed shall be at the Participant's expense.

8.35.03 The Plan may limit second medical opinions in connection with a particular diagnosis or treatment to three per Calendar Year, if additional opinions are deemed to be an unreasonable over-utilization by the Participant.

8.36 **Spinal manipulations** will be covered only when Medically Necessary and prescribed by a Participating Physician or by self-referral to a Participating Physician.

8.37 **Substance Abuse Services.** Inpatient intermediate and outpatient Substance Abuse Services are covered when Medically Necessary and may be covered when a Participant is admitted to a Participating Hospital or Other Health Care Facility.

8.37.01 Intermediate Substance Abuse Services in a Residential Treatment facility may be covered under a 24-hour intensive and structured supervised treatment program providing an inpatient level of care but in a non-Hospital environment, for those disorders that cannot be effectively treated in an outpatient or Partial Hospitalization environment. Prior Authorization is required.

8.37.02 Partial Hospitalization may be covered under a structured program of active psychiatric treatment provided in a Hospital outpatient setting or by a community mental health center, that is more intense than the care received in a Physician's or therapist's office, as an alternative to inpatient hospitalization. Prior Authorization is required.

8.37.03 Outpatient, and intensive outpatient treatment for substance use disorders may be covered when provided by a state-licensed psychiatrist or other Physician, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other qualified mental health professional as allowed under applicable state law.

8.38 **Supplies**. Ostomy, urostomy, wound care supplies and flotation pads are covered when Medically Necessary. Wound care supplies are covered as part of an approved treatment plan, when the wound is caused by or treated by a surgical procedure, or requires debridement. Provision of ostomy, urostomy and wound care supplies is limited to a one-month supply every 30 days. Items which are not medical supplies or which could be used by the Participant or a family member for purposes other than ostomy care are not covered.

8.39 **Temporomandibular Joint Dysfunction (TMJ)**. The Plan will pay benefits for covered services during a plan of treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and the skull, subject to the maximum benefit shown on the "Schedule of Benefits", if any. Expenses covered under this jaw joint benefit are not covered under any other provision of this plan.

8.39.01 The following are covered expenses:

a. A single examination including a history, physical examination, muscles testing, range of motion measurements, and psychological evaluation;

b. Diagnostic x-rays;

c. Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;

d. Therapeutic injections;

e. Appliance therapy utilizing an appliance which does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the maximum allowable fee for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance;

f. Limited to one splint in a six-month period; and

g. Surgical procedures.

8.40 **Transplant services,** limited to the procedures listed below, are covered when performed at an AvMed contracted transplant facility, subject to the conditions and Limitations described in Section IX (LIMITATIONS OF BASIC BENEFITS). Transplant services are subject to Prior Authorization. Transplant includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation.

8.40.01 Covered expense for an organ transplant includes pre-transplant services, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation of the following organs or procedures only:

a. Heart;

b. Lung(s);

c. Liver;

d. Kidney;

e. Bone marrow;

f. Intestine;

g. Pancreas;

h. Auto islet cell;

i. Any combination of the above listed organs; and

j. Any organ not listed above required by state or federal law.

8.40.02 The following are covered expenses for approved organ transplants and all related complications:

a. Hospital and health care practitioner services.

b. Organ acquisition and donor costs, including pre-transplant services, the acquisition procedure, and any complications resulting from the acquisition.

c. Direct, non-medical costs for:

i. The Participant receiving the organ transplant, if he or she lives more than 50 miles from the transplant facility; and

ii. One designated caregiver or support person (two, of the Participant receiving the organ transplant is under 18 years of age), if they live more than 50 miles from the transplant facility.

d. Direct, non-medical cost include:

i. Transportation to and from the Hospital where the organ transplant is performed; and

ii. Temporary lodging at a prearranged location when requested by the Hospital and approved by AvMed.

8.40.03 All direct, non-medical costs for the Participant receiving the organ transplant and the designated caregiver(s) or support person(s) are limited to a combination maximum coverage per organ transplant, as specified in the "Schedule of Benefits – Transplant Services" section.

8.41 **Urgent care services**. All necessary and covered services received in an Urgent Care Center, retail clinic or a Primary Care Physician's office after-hours for conditions as described in Section 2.62 will be covered by AvMed. In addition, any Participant requests for reimbursement (of payment made by the Participant for services rendered) must be filed within 90 days after the emergency or as soon as reasonably possible but not later than one year unless the Participant was legally incapacitated.

8.42 **Ventilator Dependent care**. With prior authorization by AvMed, ventilator dependent care is covered. (see Section 2.67).

IX. LIMITATIONS OF BASIC BENEFITS

The rights of Participants and obligations of Participating Providers hereunder are subject to the following Limitations:

9.01 **Cardiac rehabilitation**. Coverage of cardiac rehabilitation is limited to a maximum of 18 visits per Calendar Year.

9.02 **Chiropractic/Spinal Manipulation** is limited to 60 visits per calendar year.

9.03 **Habilitative physical, occupational & speech therapies.** When provided for the treatment of Autism Spectrum Disorder, services are limited to a combined maximum of 100 visits per calendar year.

9.04 **Home Health Care Services (Skilled Home Health Care)** visits are limited to a period of two hours or less per visit and 60 visits per Calendar Year.

9.05 **Hyperbaric oxygen treatments** are limited to 40 treatments per condition as appropriate pursuant to the Centers for Medicare and Medicaid Services (CMS) guidelines, subject to applicable Copayments as listed for physical, occupational and speech therapies.

9.06 **Licensed dietitians/nutritionists**. Visits to licensed dietitians/nutritionists for treatment of obesity control shall be limited to four outpatient visits per Calendar Year and each visit requires a Copayment. See Section 10.18.

9.07 **Mental health and substance abuse services.** Intermediate inpatient/Residential Treatment is limited to 100 days per Calendar Year.

9.08 **Orthotic appliances**. Coverage for orthotic appliances is limited to custom-made leg, arm, back and neck braces when related to a surgical procedure or when used in an attempt to avoid surgery and when necessary to carry out normal activities of daily living, excluding sports activities.

9.09 **Prosthetic devices**. Coverage for prosthetic devices is limited to artificial limbs, artificial joints, ocular prostheses and cochlear implants.

9.10 **Rehabilitative physical, occupational and speech therapy**. Coverage of outpatient physical, occupational and speech therapy is limited to a combined total of 60 visits per Calendar Year including evaluations.

9.11 **Second medical opinions**. AvMed may limit second medical opinions in connection with a particular diagnosis or treatment to three per Calendar Year, if AvMed deems additional opinions to be an unreasonable over-utilization by the Participant.

9.12 **Skilled nursing facilities and rehabilitation centers**. Routine services are covered up to a combined maximum of 100 post-hospitalization days per calendar year. Services for the treatment of mental health or substance use disorders are limited to a combined maximum of 100 days per calendar year.

9.13 **Transportation for Major Organ Transplant services**. Transportation for transplant services is administered through Optum Health, an AvMed third party partner. Charges are limited to $200 per day up to $10,000 lifetime maximum per covered organ transplant for a companion to accompany the Participant (or 2 companions when the patient is a minor) and the Participant has to travel greater than a 50 mile radius to receive the transplant. This service is available only when the transplant is authorized at one of AvMed's contracted transplant facilities.

X. EXCLUSIONS FROM BASIC BENEFITS

Medical Services and benefits for the following classifications and conditions are not covered and are excluded from the Schedule of Basic Benefits provided under this Plan:

10.01 **Aids or devices that assist with nonverbal communications**, including but not limited to communication boards, communication devices (except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx), prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs) Braille typewriters, visual alert systems for the deaf and memory books.

10.02 **Armed forces service-connected medical care** for both sickness and injury.

10.03 **Autopsy or postmortem examinations** and associated services.

10.04 **Breast reduction or augmentation**. Surgery for the reduction or augmentation of the size of the breasts unless medically necessary, except as required for the comprehensive treatment of breast cancer.

10.05 **Complementary or alternative medicine** including but not limited to, acupuncture; aromatherapy, Ayurvedic medicine such as lifestyle modifications, purification and massage therapies; behavioral training, biofield therapies; bioelectromagnetic applications and medicine; biofeedback; chelation therapy; cognitive therapy; environmental medicine including the field of clinical ecology; herbal therapies; homeopathic medicine and counseling; hypnotherapy; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; manual healing methods such as the Alexander technique, massage therapy including but not limited to: craniosacral balancing, Feldenkrais method, Hellerwork, reflexology, Rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and polarity therapy; naturopathic medicine; prayer and mental healing; Reichian therapy, Reiki, self-care and self-help training; sex therapy, SHEN therapy, sleep therapy, therapeutic touch; thermography; traditional Chinese medicine including acupuncture and vocational rehabilitation.

10.06 **Complications of any non-covered service**, including the evaluation or treatment of any condition that arises as a complication of a non-covered service.

10.07 **Cosmetic, surgical or non-surgical procedures** which are undertaken primarily to improve or otherwise modify the Participant's external appearance are excluded, except for reconstructive surgery to correct and repair a functional disorder as a result of a disease, injury, or congenital defect or initial implanted prosthesis and reconstructive surgery incident to a mastectomy for cancer of the breast. Also excluded are surgical excision or reformation of any sagging skin of any part of the body, including, but not limited to: the eyelids, face, neck, abdomen, arms, legs or buttocks; any services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body, including, but not limited to: the face, lips, jaw, chin, nose, ears, breasts or genitals (including circumcision, except newborns for up to one year from date of birth (see Section 8.19); hair transplantation, chemical face peels or abrasion of the skin, electrolysis depilation, removal of tattooing; or any other surgical or non-surgical procedures which are primarily for cosmetic purposes or to create body symmetry. Additionally, all medical complications as a result of cosmetic, surgical or non-surgical procedures are excluded.

10.08 **Cosmetics, dietary supplements, health or beauty aids**.

10.09 **Custodial Care** as defined in Section 2.18.

10.10 **Dental Care**, as defined in Section 2.19, for any condition except:

10.10.01 services, supplies or appliances for Dental Care necessary to promptly repair (but not replace), sound natural teeth required as a result of and directly related to an accidental injury sustained while covered under the Plan. Treatment must begin 90 days from date of injury and must be completed within nine months from date of injury.

10.10.02 reconstructive jaw surgery for the treatment of deformities that are present and apparent at birth; or

10.10.03 services for the treatment of tumors or full mouth extraction when required before radiation therapy.

10.11 **Diagnostic testing and treatment** related to mental retardation or deficiency, learning disabilities, behavioral problems and developmental delays. Expenses for remedial or special education, counseling, or therapy including evaluation and treatment of the above-listed conditions or behavioral training whether or not associated with manifest mental disorders or other disturbances.

10.12 **Durable Medical Equipment (DME)** items that are not covered include, but are not limited to the following:

10.12.01 bed related items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses;

10.12.02 bath related items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas;

10.12.03 chairs, lifts and standing devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is 2-person transfer), and auto tilt chairs;

10.12.04 electric or powered scooters; non-standard customized wheelchairs, motorized or manual;

10.12.05 fixtures to real property: ceiling lifts and wheelchair ramps;

10.12.06 car/van modifications;

10.12.07 air quality items: air conditioners, room humidifiers, vaporizers, air purifiers and electrostatic machines;

10.12.08 blood/injection related items: blood pressure cuffs, centrifuges, nova pens and needleless injectors; and

10.12.09 other equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment, emergency alert equipment and diathermy machines.

10.12.10 The replacement of Durable Medical Equipment solely because it is old or used is excluded.

10.13 **Emergency room services for non-emergency purposes**. See Sections 2.20 and 2.21.

10.14 **Exercise programs,** gym memberships, or exercise equipment of any kind, including, but not limited to: exercise bicycles, treadmills, stair-masters, rowing machines, free weights or resistance equipment. Also excluded are massage devices, portable whirlpool pumps, hot tubs, Jacuzzis, sauna baths, swimming pools and similar equipment.

10.15 **Experimental and/or Investigational procedures**, except for bone marrow transplants, as approved per Section 59B-12.001, Florida Administrative Code, and clinical trials as set forth in Section 8.03.06.

10.16 **Eye care including**:

10.16.01 eye examinations for Participants 18 years of age or older for the purpose of determining the need for sight correction (such as eye glasses or contact lenses);

10.16.02 training or orthoptics, including eye exercises; or

10.16.03 radial keratotomy, refractory keratoplasty, Lasik surgery or any other corneal surgical procedure to correct refractive error.

10.17 **Foot supports** are not covered, except for arch supports (foot orthotics) and orthopedic shoes for diabetes and hammertoe. 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.

10.18 **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.

10.19 **Gender reassignment** surgery as well as any service, supply, or medical care associated with gender reassignment or gender identity disorders.

10.20 **Home monitoring devices and measuring devices** (other than apnea monitors), and any other equipment or devices for use outside the Hospital.

10.21 **Hospital Services that are associated with excluded surgery or excluded Dental Care**.

10.22 **Hearing examinations for Participants 18 years of age or older** for the purpose of determining the need for hearing correction.

10.23 **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.

10.24 **Immunizations and medications** for the purpose of foreign travel or employment.

10.25 **Mandibular and maxillary osteotomies** except when Medically Necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.

10.26 **Medical care or surgery not authorized by a Participating Provider**, except for Emergency Medical Services and Care, or not within the benefits covered by this Plan.

10.27 **Medical supplies** including, but not limited to: pre-fabricated splints, Thromboemboletic/Support hose and all other bandages, except as provided in Sections 8.11 and 8.38.

10.28 **Mental Health Services** shall not be covered if treatment is:

10.28.01 rendered in connection with a condition not classified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association; or

10.28.02 extended beyond the period necessary for diagnosis of learning and behavioral disabilities or for mental retardation; or

10.28.03 for marriage counseling; or

10.28.04 court ordered care or testing or required as a condition of probation or parole; or

10.28.05 testing for aptitude, ability, intelligence, or interest.

10.29 **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 2.20 and 2.21), including Hospital care from a non-participating Attending Physician or a non-participating Hospital, if elected by a Participant. 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.

10.30 **Nutrition Therapy**. Vitamins, dietary supplements, and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).

10.31 **Over-the-counter medications** and prescription medications not otherwise covered including all contraceptives (medications and devices), hypodermic needles and syringes and Injectable Medications except insulin and insulin syringes for the treatment of diabetes as outlined in Sections 8.06 and 8.07.

10.32 **Personal comfort items** not Medically Necessary for proper medical care as part of the therapeutic plan to treat or arrest the progression of an illness or injury. This Exclusion includes, but is not limited to: wigs (including partial hair pieces, weaves, and toupees), 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 8.01), air conditioners, humidifiers, dehumidifiers, and air purifiers or filters.

10.33 **Physical examinations or tests**, such as premarital blood tests or tests for continuing employment, education, licensing, or insurance or that are otherwise required by a third party.

10.34 **Physical, occupational, speech and all other therapies for chronic conditions**. Maintenance therapy is not covered. Maintenance therapy begins when the therapeutic goals of a treatment plan have been met and/or no further functional progress is expected. Speech therapy for non-organic or functional disorders is not covered, except for the initial evaluation to determine the root cause. Examples include attention deficit disorder, developmental delay, mental retardation, and Down's syndrome. Abnormal speech pathology, including but not limited to lisping and stuttering, is not covered.

10.35 **Private duty nursing services**.

10.36 **RehabilitationServices**. Vocational rehabilitation, pulmonary rehabilitation or long term rehabilitation programs.

10.37 **Reversal of sterilization procedures**.

10.38 **Sexual dysfunction**. All medications, devices, and other forms of treatment related to a diagnosis of sexual dysfunction resulting from a medical condition.

10.39 **Surgically implanted devices** and any associated external devices, except for cardiac pacemakers, intraocular lenses, cochlear implants, artificial joints, orthopedic hardware, vascular grafts, and ventricular assist devices, if indicated, when used as a bridge to heart transplantation. Dental appliances, other corrective lenses and hearing aids, including the professional fee for fitting them, are not covered.

10.40 **Temporomandibular Joint Dysfunction (TMJ).** Covered expenses do not include:

10.40.01 Computed Tomography (CT) scans or magnetic resonance imaging except in conjunction with surgical management;

10.40.02 Electronic diagnostic modalities;

10.40.03 Occlusal analysis; or

10.40.04 Any irreversible procedure, including, but not limited to: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures, full dentures.

10.41 **Termination of pregnancy** unless deemed Medically Necessary by the Medical Director, subject to applicable State and Federal laws. Coverage is available if the pregnancy would endanger the life of the mother, if the pregnancy is a result of rape or incest, or the fetus has been diagnosed with a lethal or otherwise significant abnormality.

10.42 **Transplant services,** no benefit is payable for or in connection with an organ transplant if:

10.42.01 It is experimental or investigational, or for research purposes unless the particular use of the bone marrow transplant procedure is determined to be accepted within in the appropriate oncological specialty and not experimental pursuant to 627.4236 (3).

10.42.02 The expense relates to storage of cord blood and stem cells, unless it is an integral part of an organ transplant approved by AvMed.

10.42.03 AvMed does not approve coverage for the organ transplant, based on our established criteria.

10.42.04 Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.

10.42.05 The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the master group contract.

10.42.06 The expense related to the donation or acquisition of an organ for a recipient who is not covered by the Plan.

10.42.07 The expense relates to an organ transplant performed outside of the United States and any care resulting from that organ transplant.

10.42.08 A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow-up care, immunosuppressive drugs, and expenses related to complications of such transplant.

10.42.09 You have not met pre-transplant criteria as established by AvMed.

10.43 **Travel expenses** including expenses for ambulance services to and from a Physician or Hospital except in accordance with Section 8.01. Ambulance services are not covered when the skill of medically trained personnel is not required and the Participant can be safely transported by other means.

10.44 **Treatment of a condition resulting from**:

10.44.01 participation in a riot or rebellion;

10.44.02 engagement in an illegal occupation;

10.44.03 participation in, or commission of, any act punishable by law as a felony whether or not the individual is charged or convicted.

10.45 **Workers' Compensation benefits**. Any sickness or injury for which the Participant is paid benefits, or may be paid benefits if claimed, if the Participant is covered or required to be covered by Workers' Compensation. In addition, if the Participant enters into a settlement giving up rights to recover past or future medical benefits under a Workers' Compensation law, the Plan shall not cover past or future Medical Services that are the subject of or related to that settlement. Furthermore, if the Participant is covered by a Worker's Compensation program that limits benefits if other than specified health care providers are used and the Participant receives care or services from a health care provider not specified by the program, the Plan shall not cover the balance of any costs remaining after the program has paid.

XI. COORDINATION OF BENEFITS

11.01 The services and benefits provided under this Plan are not intended to and do not duplicate any benefit to which Participants are entitled under any other Group Health Insurance, HMO, personal injury protection and medical payments under the automobile insurance laws of this or any other jurisdiction, governmental organization, agency, or any other entity providing health or accident benefits to a Participant, including but not limited to: Medicare, Worker's Compensation, Public Health Service, CHAMPUS, Maritime Health Benefits, or similar state programs as permitted by contract, policy, or law. Plan coverage will be primary to Medicaid and Children's Health Insurance Program (CHIP) benefits.

11.02 If any Participant is eligible for services or benefits under two or more plans as set forth in Section 11.01, 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 Participant shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure

such rights to the Plan. Failure to do so will result in nonpayment of Claims. Requested information should be provided to AvMed within 30 days of request or Participant will be responsible for payment of the Claim. Information received after one year from date of service will not be considered.

11.03 The standards governing the coordination of benefits are the following, in accordance with the provisions of Chapter 627.4235, *Florida Statutes*:

11.03.01 The benefits of a policy or plan that covers the person as a Covered Employee or Participant, other than as a Dependent, are determined before those of the policy or plan which covers the person as a Dependent.

11.03.02 Except as stated in Section 11.03.03, when two or more policies or plans cover the same child as a Dependent of different parents:

a. The benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls earlier in a year are determined before 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.

11.03.03 If two or more policies or plans cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

a. First, the policy or plan of the parent with custody of the child;

b. Second, the policy or plan of the spouse of the parent with custody of the child; and

c. Third, the policy or plan of the parent not having custody of the child.

d. However, if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the child and if the entity obliged to pay or provide the benefits of the policy or plan of that parent has actual knowledge of those terms, the benefits of that policy or plan are determined first. This does not apply with respect to any claim determination period or plan or policy year during which any benefits are actually paid or provided before that entity has that actual knowledge.

11.03.04 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 Section shall not apply.

11.03.05 If none of the rules in Sections 11.03.01 through 11.03.04 determine the order of benefits, the benefits of the policy or plan which covered an employee, Participant 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.

11.03.06 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, Participant, or subscriber.

b. Second, benefits of a plan of an active worker covering a person as a Dependent.

c. Third, Medicare benefits.

11.03.07 Medicare shall be considered the secondary plan and this Plan shall be considered the primary plan with respect to the following Participants entitled to Medicare:

a. For Medicare entitlement due to age, active employees and their spouses;

b. For Medicare entitlement due to disability, employees under this Plan due to current employment status and their family Members;

c. For Medicare entitlement due to end-stage renal disease, all Participants during the first 30 months of Medicare entitlements.

d. For all other covered persons entitled to Medicare, this Plan shall be secondary plan. When this Plan is secondary to Medicare, the amount payable under this Plan shall be reduced by the amount payable under Medicare, if any, regardless of whether the covered person has enrolled in Medicare.

11.03.08 If an individual is covered under COBRA continuation coverage and also under another group plan, the following order of benefits applies:

a. First, the plan covering the person as an employee or as the employee's Dependent.

b. Second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's Dependent provided according to the provisions of COBRA.

11.04 For the purpose of determining the applicability and implementing the terms of the Coordination of Benefits provision of the Plan, AvMed may, without the consent of or notice to any person, release to or obtain from any other insurance company, organizations or person, any information, with respect to any Participant, or applicant for participation, which AvMed deems to be necessary for such purposes.

11.05 Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts the Plan shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan.

11.06 All treatments must be Medically Necessary and comply with all terms, conditions, Limitations, and Exclusions of this Plan even if this Plan is secondary to other coverage and the treatment is covered under the other coverage.

11.07 If the amount of the payments made by the Plan is more than it should have paid under the provisions of this Section XI, 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 Participant. The 'amount of the payments made' includes the reasonable cash value of any benefits provided in the form of services.

11.08 In the event the Employer 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.

XII. SUBROGATION AND RIGHT OF RECOVERY

12.01 If the Plan provides health care benefits to a Participant for injuries or illness for which another party is or may be responsible, then the Plan retains the right to repayment of the full cost of all benefits provided by the Plan on behalf of the Participant that are associated with the injury or illness for which another party is or may be responsible. The Plan's rights of recovery apply to any recoveries made by or on behalf of the Participant from the following third-party sources, as allowed by law, including but not limited to: payments made by a third-party tortfeasor or any insurance company on behalf of the third-party tortfeasor; any payments or awards under an uninsured or underinsured motorist coverage policy; any worker's compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; any other payments from a source intended to compensate a Participant for injuries resulting from an accident or alleged negligence. For purposes of this SPD, a tortfeasor is any party who has committed injury, or wrongful act done willingly, negligently or in circumstances involving strict liability, but not including breach of contract for which a civil suit can be brought.

12.02 Participant specifically acknowledges the Plan's right of subrogation. When the Plan provides health care benefits for injuries or illnesses for which a third party is or may be responsible, the Plan shall be subrogated to the Participant's rights of recovery against any party to the extent of the full cost of all benefits provided by the Plan, to the fullest extent permitted by law. The Plan may proceed against any party with or without the Participant's consent.

12.03 Participant also specifically acknowledges the Plan's right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when the Plan has provided health care benefits for injuries or illness for which another party is or may be responsible and the Participant and/or the Participant's representative has recovered any amounts from the third party or any party making payments on the third party's behalf. By providing any benefit under this SPD, the Plan is granted an assignment of the proceeds of any settlement, judgment or other payment received by the Participant to the extent of the full cost of all benefits provided by the Plan. The Plan's right of reimbursement is cumulative with and not exclusive of the Plan's subrogation right and the Plan may choose to exercise either or both rights of recovery.

12.04 Participant and the Participant's representatives further agree to:

12.04.01 notify the Plan promptly and in writing when notice is given to any third party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by the Participant that may be the legal responsibility of a third party; and

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

12.04.03 give the Plan a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from a third party to the extent of the full cost of all benefits associated with injuries or illness provided by the Plan for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement); and

12.04.04 pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due the Plan as reimbursement for the full cost of all benefits associated with injuries or illness provided by the Plan for which a third party is or

may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement), unless otherwise agreed to by the Plan in writing; and

12.04.05 do nothing to prejudice the Plan's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery, which specifically attempts to reduce or exclude the full cost of all benefits, provided by the Plan.

12.05 The Plan may recover the full cost of all benefits provided by the Plan under this SPD without regard to any claim of fault on the part of the Participant, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. In the event the Participant or the Participant's representative fails to cooperate with the Plan, the Participant shall be responsible for all benefits paid by the Plan in addition to costs and attorney's fees incurred by the Plan in obtaining repayment.

XIII. DISCLAIMER OF LIABILITY

13.01 Neither AvMed nor the Plan directly employs any practicing Physicians nor any Hospital personnel or Physicians. These health care providers are independent contractors and are not the agents or employees of 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 Participants and are solely responsible for all Medical Services which Participating Providers render to Participants. Therefore, AvMed nor the Plan shall be liable for any negligent act or omission committed by any independent practicing Physicians, nurses or medical personnel, nor any Hospital or health care facility, its personnel, other health care professionals or any of their employees or agents who may, from time to time, provide Medical Services to a Participant. Furthermore, neither AvMed nor the Plan shall be vicariously liable for any negligent act or omission of any of these independent health care professionals who treat a Participant of the Plan.

13.02 Certain Participants may, for personal reasons, refuse to accept procedures or treatment recommended by Participating Physicians. Participating Physicians may regard such refusal to accept their recommendations as incompatible with the continuance of the Physician/patient relationship and as obstructing the provision of proper medical care. If a Participant 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 Participant shall be so advised. If the Participant continues to refuse the recommended treatment or procedure, the Employer may terminate the Participant's coverage under this Plan as set forth in Section 7.01.03.

XIV. REVIEW PROCEDURE

14.01 **Complaints**. Participants have the right to a review of any complaint regarding the services or benefits covered under the Plan. If a Participant has a complaint regarding Plan services, including quality of service, office wait time, Physician behavior and other concerns, the Participant or someone he names to act on his behalf (an authorized representative) may call AvMed's Member Services Department at 1-844-263-2369. AvMed encourages the informal resolution of complaints relating to Plan services, and Member Services Representatives will work with complainants to resolve any such issues over the telephone. If a complainant asks for a written response, or if a complaint is related to quality of care, AvMed will respond in writing. The Member Services Department can also advise how to name an authorized representative.

14.02 **Grievances**. A grievance is any complaint other than one that involves a request (Claim) for benefits, or a request for review of an Adverse Benefit Determination. If a complaint cannot be resolved informally over the telephone, the Participant or his authorized representative may submit the complaint to AvMed,

in writing. This is referred to as 'filing a grievance'. The written grievance will be processed through AvMed's formal grievance procedures.

14.02.01 Grievances must be filed within one year from the date of the event or action that led to the grievance. AvMed will acknowledge and investigate the grievance, and provide a written response advising of the disposition within 60 days after receipt of the grievance. A grievance may be submitted in writing to:

AvMed Member Services – North
P.O. Box 823
Gainesville, Florida 32602-0823
Telephone: 1-844-263-2369
Fax: (352) 337-8612

14.03 **Claims for benefits**. The Employer has delegated to AvMed the discretionary authority to interpret the Plan and to make initial claim determinations. The Employer has delegated to AvMed the discretionary authority to make final internal claim review decisions on appeal. The Employer retains the authority to determine whether employees and their Dependents are eligible to enroll for or continue coverage under the Plan.

14.03.01 **Pre-Service Claims**

a. **Initial Claim**. A Pre-Service Claim for benefits will be deemed to have been filed on the date received by AvMed, on the Plan's behalf. 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 receipt of the Pre-Service Claim.

i. AvMed may extend this period one time for up to 15 additional days, provided that it determines 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 it expects to render a decision. If such an extension is necessary because the Claimant failed to provide sufficient information to decide the Claim, the notice of extension will specifically describe the required information and the Claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

ii. 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 follow in filing a Claim for benefits, not later than five days following such failure.

iii. AvMed's period for making the benefit determination will be tolled from the date the notification of the extension is sent to the Claimant, until the date the Claimant responds to the request for the required information. If the Claimant fails to supply the requested information within the 45-day period, the Claim will be denied.

b. **Appeal**. A Claimant may appeal an Adverse Benefit Determination with respect to a Pre-Service Claim within 180 days of receiving notification of such determination. The Claimant will be notified, in accordance with Section 14.03.07, of the Plan's determination on review within a reasonable period of time, but not later than 30 days after receipt of the appeal. An appeal may be submitted to:

AvMed Member Relations

P. O. Box 749
Gainesville, Florida 32627
Telephone: 1-844-263-2369
Fax: (352) 337-8794

i. If a Claimant wishes AvMed to review a denial prior to filing an appeal, he may call AvMed's Member Services Department at 1-844-263-2369 or submit the request in writing to:

AvMed Member Relations
P.O. Box 749
Gainesville, FL 32602-0749

ii. Additional information may be provided to clarify or support the claim. Persons who were not involved in the initial determination will conduct an internal review. A decision will be made within 30 working days and written notification will be provided to the Claimant. However, this process in no way extends the 180 day appeal period.

c. **External Review**. In the event of a final internal Adverse Benefit Determination with respect to a Pre-Service Claim, a Claimant may be entitled to request that the claim be sent for review by an external reviewer. This request must be received within 180 days of receipt of the Adverse Benefit Determination. The external reviewer will render a recommendation within a reasonable period of time after receipt of the claim, not to exceed 45 calendar days unless the request meets expedited criteria, in which case it will be resolved as soon as administratively possible, but not later than 72 hours. The external reviewer's recommendation will be binding. The external reviewer will notify the Claimant of its decision in writing, and the Plan will take action as appropriate to comply with such recommendation. For further information about the external review process, please contact AvMed's Member Services Department.

14.03.02 **Urgent Care Claims**

a. **Initial Claim**. An Urgent Care Claim for benefits, either oral or written, will be deemed to have been filed on the date it is received by AvMed on the Plan's behalf. AvMed will notify the Claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Urgent Care Claim.

i. If the Claimant fails to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan, AvMed will notify the Claimant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information required to complete the Claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances but not less than 48 hours, to provide the specified information.

ii. AvMed will notify the Claimant of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of AvMed's receipt of the specified information or the end of the period afforded the Claimant to provide the specified information.

iii. If the Claimant fails to supply the specified information within the 48-hour period, the Claim will be denied. AvMed will 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 14.03.05 will be provided to the Claimant no later than three days after the oral notification.

b. **Appeal**. A Claimant may appeal an Adverse Benefit Determination with respect to an Urgent Care Claim within 180 days of receiving notification of such determination. The Claimant will be notified, in accordance with Section 14.03.07, of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's appeal. The address for submitting an appeal is provided in Section 14.03.01b.

c. **External Review**. In the event of a final internal Adverse Benefit Determination with respect to an Urgent Care Claim, a Claimant may be entitled to request that the claim be sent for review by an external reviewer. This request must be received within 180 days of receipt of the Adverse Benefit Determination. The external reviewer will render a recommendation within a reasonable period of time after receipt of the claim, not to exceed 45 calendar days unless the request meets expedited criteria, in which case it will be resolved as soon as administratively possible, but not later than 72 hours. The external reviewer's recommendation will be binding. The external reviewer will notify the Claimant of its decision in writing, and the Plan will take action as appropriate to comply with such recommendation. For further information about the external review process, please contact AvMed's Member Services Department.

14.03.03 **Concurrent Care Claims**

a. Any reduction or termination of Concurrent Care by AvMed before the end of an approved period of time or number of treatments (other than by Plan amendment or termination), will constitute an Adverse Benefit Determination. AvMed will notify the Claimant, in accordance with Section 14.03.05, 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 final determination on review (including external review), before the benefit is reduced or terminated.

b. With respect to an Urgent Care Claim, any request by a Claimant to extend a course of treatment beyond a previously approved period of time or number of treatments will be decided as soon as possible, taking into account the medical exigencies, and AvMed will notify the Claimant of the benefit determination (whether adverse or not) within 24 hours after receipt of the Claim, provided that any such Claim is made to AvMed at least 24 hours before the expiration of the previously approved period of time or number of treatments. Notification and appeal of any Adverse Benefit Determination with respect to a request to extend a course of treatment, whether involving an Urgent Care Claim or not, will be made in accordance with Sections 14.03.05 through 14.03.07.

14.03.04 **Post Service Claims**

a. **Initial Claim**. A Post-Service Claim for benefits will be deemed to have been filed on the date it is received by AvMed. AvMed will notify the Claimant in accordance with Section 14.03.05, of the benefit determination, within a reasonable period of time but not later than 30 days after receipt of the Post-Service Claim.

i. AvMed may extend this period one time for up to 15 days, provided that it determines 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 it expects to render a decision. If such an extension is necessary because

the Claimant failed to provide sufficient information to decide the Claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

ii. AvMed's period for making the benefit determination will be tolled from the date the notification of the extension is sent to the Claimant, until the date the Claimant responds to the request for the required information. If the Claimant fails to supply the requested information within the 45-day period, the Claim will be denied.

b. **Appeal**. A Claimant may appeal an Adverse Benefit Determination with respect to a Post-Service Claim within 180 days of receiving notification of such determination. The Claimant will be notified, in accordance with Section 14.03.07, of the Plan's determination on review within a reasonable period of time, but not later than 60 days after receipt of the Claimant's appeal. The address for submitting an appeal is provided in Section 14.03.01b.

c. **External Review**. In the event of a final internal Adverse Benefit Determination with respect to a Post Service Claim, a Claimant may be entitled to request that the claim be sent for review by an external reviewer. This request must be received within 180 days of receipt of the Adverse Benefit Determination. The external reviewer will render a recommendation within a reasonable period of time after receipt of the claim, not to exceed 45 calendar days unless the request meets expedited criteria, in which case it will be resolved as soon as administratively possible, but not later than 72 hours. The external reviewer's recommendation will be binding. The external reviewer will notify the Claimant of its decision in writing, and the Plan will take action as appropriate to comply with such recommendation. For further information about the external review process, please contact AvMed's Member Services Department.

14.03.05 **Manner and content of initial claims determination notification**. AvMed will provide a Claimant with written notification of any Adverse Benefit Determination. The notification will set forth, in a manner calculated to be understood by the Claimant, the following:

a. Sufficient information to identify the claim, including (as applicable) the date of service, health care provider, and claim amount, as well as notice that the diagnosis and treatment codes along with the corresponding meaning are available upon request and free of charge.

b. The specific reason for the Adverse Benefit Determination including the denial code and its corresponding meaning;

c. A description of the specific benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, and a statement that a copy of such provision, guideline, protocol or other similar criterion will be provided free of charge to the Claimant upon request;

d. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;

e. If the denial decision is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances;

f. 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;

g. A description of appeal rights and AvMed's review procedures and the time limits applicable to such procedures following an Adverse Benefit Determination on final review.

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

14.03.06 **Review procedure upon appeal**. To provide Claimants a full and fair review, AvMed's review process will include the following substantive procedures and safeguards:

a. Claimants may present evidence and testimony, and may submit written comments, documents, records and other information relating to the Claim.

b. Upon request and free of charge, Claimants will have reasonable access to and copies of documents, records, and other information relevant to the claim, and will be permitted to review the Claim file.

c. The review will 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.

d. The review will be conducted by an appropriate named fiduciary of AvMed who is neither the individual nor a subordinate of the individual who made the initial Adverse Benefit Determination. Such person will not be subject to promotion, raises, bonuses, etc. based on whether they approve or deny any claim. Such person will not defer to the initial Adverse Benefit Determination.

e. Review by the appropriate named fiduciary, of any Adverse Benefit Determination based in whole or in part on a medical judgment, including determination as to whether a particular treatment, medication, or other item is Experimental and/or Investigational or not Medically Necessary, will include consultation with a Health Professional who has appropriate training and experience in the field of medicine relevant to the medical judgment.

f. Review will provide 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.

g. The review will provide that the Health Professional engaged for purposes of a consultation as referenced in Section 14.03.06e will be an individual who is neither the individual nor a subordinate of the individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal.

h. In the case of an Urgent Care Claim, there will be an expedited review process available pursuant to which:

i. Request for an expedited review of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and

ii. All necessary information, including AvMed's benefit determination on review, will be transmitted between AvMed and the Claimant by telephone, facsimile or other available similarly expeditious methods.

i. If any new or additional evidence considered, relied upon, or generated by or at the direction of the Plan in connection with a claim results in a final internal adverse benefit determination, Claimants will be provided free of charge with such new or additional evidence as soon as possible, and sufficiently in advance of the due date for the notice, so that Claimants have a reasonable opportunity to respond prior to the due date.

j. If a new or additional rationale in connection with a claim results in a final internal adverse benefit determination, Claimants will be provided free of charge with such new or additional rationale as soon as possible, and sufficiently in advance of the due date for the notice, so that Claimants have a reasonable opportunity to respond prior to the due date.

14.03.07 **Manner and content of final review notification**. AvMed will provide a Claimant with written notification of its benefit determination upon review.

a. In the case of a final internal adverse benefit determination, the notification will set forth, in a manner calculated to be understood by the Claimant, all of the following as appropriate:

b. Sufficient information to identify the claim, including (as applicable) the date of service, health care provider, and claim amount, as well as notice that the diagnosis and treatment codes along with the corresponding meaning, are available upon request and free of charge.

c. The specific reason for the Adverse Benefit Determination including the denial code and its corresponding meaning;

d. A description of the specific benefit provision, guideline, protocol or other similar criterion on which the denial decision is based and a discussion of such benefit provision, guideline, protocol or other similar criterion.

e. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;

f. If the denial decision is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances.

g. A statement describing any voluntary appeal procedures offered by AvMed and the Claimant's right to obtain the information about such procedures.

14.03.08 If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent 3rd party, who will review the denial and issue a final decision. You may contact AvMed Member Services at 1-844-263-2369 with any questions on your rights to external review. Please understand that if you want to be informed about the legal remedies that may be available to you and whether they are a better option for you than seeking independent external review, you should consult a lawyer of your choice. AvMed cannot provide you with legal advice. We can only explain the procedures for obtaining independent external review.

XV. MISCELLANEOUS

15.01 **Agent for service of legal process**. The name of the person designated as the agent for service of legal process on behalf of the Plan is the Mayor, City of Sunrise, 10770 W. Oakland Park Blvd., Sunrise, Florida, 33351. Additionally, service of legal process may be made on the Plan Administrator.

15.02 **Clerical errors**. Clerical errors shall neither deprive any individual Participant of any benefits or coverage provided under the Plan nor shall such error(s) act as authorization of benefits or coverage for the Participant that is not otherwise validly in force. Retroactive adjustments in coverage, for clerical errors or otherwise will only be done for up to a 60 day period from the date of notification. Refunds of administrative service fees are done for up to a 60 day period from the date of notification. Refunds of administrative service fees 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.

15.03 **Collective Bargaining Agreement**. If the coverage under the Plan is intended to satisfy a benefit obligation under an applicable collective bargaining agreement, please note that the Plan will govern all benefit determinations and all other determinations under the Plan. The collective bargaining agreement does not influence or control, and is not to be considered to be incorporated with, the Plan in any fashion.

15.04 **Gender**. Whenever used, the singular shall include the plural and the plural the singular and the use of any gender shall include all genders.

15.05 **Identification cards**. Cards issued by AvMed to Participants pursuant to the Plan are for purposes of identification only. Possession of an identification card confers no right to health services or other benefits under the Plan. To be entitled to such services or benefits the holder of the card must, in fact, be a Participant on whose behalf all applicable charges under the Plan have actually been paid and accepted by the Plan.

15.06 **Individual information**. Participants or other individuals shall complete and submit to the Plan such applications, forms or statements as the Plan may reasonably request. If the Participant or other individual fails to provide accurate information that the Plan deems material to providing coverage for such individual, upon ten days written notice, the Plan may deny coverage and/or participation in the Plan to such individual

15.07 **Non-waiver**. The failure of the Plan to enforce any of the provisions of the Plan or to exercise any options herein provided or to require timely performance by any Participant or the Employer of any of the provisions herein, shall not be construed to be a waiver of such provisions nor shall it affect the validity of the Plan or any part thereof or the right of the Plan to thereafter enforce each and every such provision.

15.08 **Plan administration**. The Employer may from time to time adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan.

15.09 **Waiver**. A Claim that has not been timely filed with the Plan within one year of date of service shall be considered waived.

SUMMARY PLAN DESCRIPTION INFORMATION

Official Plan Name:	City of Sunrise Group Medical Plan
Plan Sponsor:	City of Sunrise 10770 W. Oakland Park Blvd. Sunrise, Florida 33351 (954) 572-2496
Plan Administrator:	Risk Manager City of Sunrise 10770 W. Oakland Park Blvd. Sunrise, Florida 33351 (954) 572-2496
Claims Administrator:	AvMed, Inc.
Plan Year:	01/01/2015 – 12/31/2015
Effective Date of the Plan:	01/01/2015
Employer Identification No.:	59-0944587
Plan Type:	Self-insured welfare benefit plan
Source of Funding for the Plan:	The Employer has elected to create a self-insured group medical plan. The Employer has purchased individual and aggregate stop-loss coverage through Symetra.
Sources of Contribution:	Employer and Employees
Agent for Service of Legal Process:	Mayor City of Sunrise 10770 W. Oakland Park Blvd. Sunrise, Florida 33351
Organization that Provides the Benefit:	Benefits under the plan are provided through an Administrative Services Agreement with AvMed, Inc.

SIGNATURE PAGE

CITY OF SUNRISE
PLAN DOCUMENT ACCEPTANCE STATEMENT
FOR THE
HMO OPTION

City of Sunrise hereby adopts the January 2015 Summary Plan Description as the Plan Document of the City of Sunrise Group Medical Plan.

NAME	TITLE	Date
Bill Mason	Risk Manager	7/8/2015
Bill MASON Resolution # 14-107		

NAME TITLE Date

Summary Plan Description
of the
Point of Service Option
for the
City of Sunrise Group Medical Plan

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9400 S. DADELAND BLVD.
MIAMI, FL 33156-9004

AVMED MEMBER SERVICES - ALL AREAS
1-844-263-2369

SERVICE AREAS

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Miami, Florida 33156-9004
(305) 671-5437
(800) 432-6676
Miami-Dade

FT. LAUDERDALE
13450 West Sunrise Boulevard
Suite 370
Sunrise, Florida 33323-2947
(954) 462-2520
(800) 368-9189
Broward
Palm Beach

ORLANDO
1800 Pembrook Drive
Suite 190
Orlando, Florida 32810
(407) 539-0007
(800) 227-4848
Lake
Orange
Osceola
Seminole

GAINESVILLE
4300 Northwest 89th Boulevard
Post Office Box 749
Gainesville, Florida 32606-0749
(352) 372-8400
(800) 346-0231
Alachua
Bradford
Citrus
Columbia
Dixie
Gilchrist
Hamilton
Levy
Marion
Suwannee
Union

JACKSONVILLE
1300 Riverplace Boulevard
Suite 640
Jacksonville, Florida 32207
(904) 858-1300
(800) 227-4184
Baker
Clay
Duval
Nassau
St. Johns

TAMPA BAY/ SOUTHWEST FLORIDA
1511 North Westshore Boulevard
Suite 450
Tampa, Florida 33607
(813) 281-5650
(800) 257-2273
Hernando
Hillsboro
Lee
Pasco
Pinellas
Polk
Sarasota

I. INTRODUCTION

Your employer has contracted with AvMed, Inc. (hereinafter 'AvMed') to arrange for the provision of Medical Services or benefits which are Medically Necessary for the diagnosis and treatment of Participants through a network of contracted independent Physicians and Hospitals and other health care providers. A Participant's choice of providers and where they receive services will determine the level of benefits they receive. Under this Plan, a Participant may choose to receive services from an In-Network Provider (payable at the In-Network Benefit Level, or an Out-of-Network Provider (payable at the Out-of-Network Benefit Level).

AvMed, in arranging for the delivery of Medical Services or benefits, does not directly provide these Medical Services or benefits. AvMed arranges for the provision of said services in accordance with the covenants and conditions contained in this Summary Plan Description. AvMed will rely upon the statements of the Participant in his application in providing coverage and benefits hereunder.

You Must Enroll to Receive Benefits! You must affirmatively enroll to receive benefits under the Plan, as explained in Section III (ELIGIBILITY). If you do not take the actions outlined in Section III to affirmatively enroll to receive benefits, you will **not** be entitled to any benefits of any kind under this Plan.

This document is a Summary Plan Description ('SPD') of the medical benefits provided to you by the City of Sunrise (the 'Employer') under the City of Sunrise Group Medical Plan (hereinafter, the 'Plan'). This SPD is made available for your reference and is subject to various legal requirements, including the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Unless otherwise noted in this document, if the terms of this document and the terms of the Plan conflict, the Plan document shall control.

The Employer may designate any other third-party administrators or claims administrators to carry out certain Plan duties and responsibilities. The Employer is responsible for formulating and carrying out all rules and procedures necessary to administer the Plan. The Employer, as Plan Sponsor, has the discretionary authority to (1) make decisions regarding the interpretation or application of Plan provisions, (2) determine the rights, eligibility, and benefits of Participants and beneficiaries under the Plan, and (3) review claims under the Plan. The Employer may delegate to a third party any or all such discretionary authority described above. Benefits under the Plan will be paid only if the Employer, as Plan Sponsor, or its designee or delegate decides in its discretion that the applicant is entitled to them.

The Plan may be amended at any time. Such amendments, for example, may (1) increase or otherwise change the cost to you for coverage, (2) change the type of benefits provided under the Plan, the conditions of participation and any other terms of the Plan, (3) require additional contributions from Participants, or (4) terminate the Plan in whole or in part at any time. Plan provisions will be administered in accordance with any appropriate collective bargaining agreement.

The Plan is not intended to and does not cover or provide any Medical Services or benefits that are not Medically Necessary for the diagnosis and treatment of the Participant. The determination as to which services are Medically Necessary shall be made by the Plan subject to the terms and conditions of the Plan. Claims for benefits are to be sent to AvMed.

Notwithstanding any references for definitional purposes to the contrary, this Plan is not an HMO product and is not subject to Chapter 641 of the *Florida Statutes*, nor is a Participant of the Plan afforded any individual rights under Chapter 641 of the *Florida Statutes*. Premiums for employees and their families are paid in part by the Employer as Plan Sponsor out of its general assets, and in part by employees' after-tax and before tax payroll deductions.

The Medical and Hospital Services covered by the Plan shall be provided without regard to the race, color, religion, physical handicap, or national origin of the Participant in the diagnosis and treatment of patients; in the use of equipment and other facilities; or in the assignment of personnel to provide services, pursuant to the

provisions of Title VI of the Civil Rights Act of 1964, as amended, and the Americans with Disabilities Act of 1990.

II. DEFINITIONS

For further definitions, go to www.healthcare.gov/glossary to review the glossary provided as a result of the Affordable Care Act.

As used in this SPD, each of the following terms shall have the meaning indicated:

2.01 **Accidental Dental Injury** means an injury to sound natural teeth caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

2.02 **Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part), for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part), for a benefit resulting from the application of any Utilization Management Program, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary; and including a cancellation or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

2.03 **Applied Behavior Analysis** means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. Applied Behavior Analysis services shall be provided by an individual certified pursuant to Section 393.17, *Florida Statutes*, or an individual licensed under Chapter 490 or Chapter 491, *Florida Statutes* or if applicable, equivalent or similar laws of another state.

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

2.05 **Autism Spectrum Disorder** means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

2.05.01 Autistic disorder;

2.05.02 Asperger's syndrome;

2.05.03 Pervasive developmental disorder not otherwise specified.

2.06 **AvMed Network** means the providers and facilities that have contracted with AvMed to provide covered services to Participants. The Participants' Copayment, Deductible and/or Coinsurance responsibilities are outlined in the Schedule of Benefits.

2.07 **Behavioral Health** is the scientific study of the emotions, behaviors and biology relating to a person's mental well-being, their ability to function in everyday life and their concept of self. Behavioral Health is the preferred term to mental health. A person struggling with his or her Behavioral Health may face stress, depression, anxiety, relationship problems, grief, addiction, ADHD or learning disabilities, mood disorders, or other psychological concerns. Counselors, therapists, life coaches, psychologists, nurse practitioners or Physicians can help manage Behavioral Health concerns with treatments such as therapy, counseling, or medication.

2.08 **Benefit Level** means:

2.08.01 For In-Network providers, the Copayment or Coinsurance percentage of the contracted rate shown in the Schedule of Benefits after the applicable Deductible is met; or

2.08.02 For Out-of-Network Providers, the Maximum Allowable Payment for covered services shown in the Schedule of Benefits after the applicable Deductible is met; or

2.08.03 The Deductible may not apply to all covered services. See Schedule of Benefits.

2.09 **Calendar Year** means the twelve-month period beginning January 1st and ending December 31st.

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

2.11 **Claimant** means a Participant or a Participant's authorized representative acting on behalf of the Participant. AvMed may establish procedures for determining whether an individual is authorized to act on behalf of the Participant. If the Claim is an Urgent Care or Pre-Service Claim, a Health Professional, with knowledge of the Participant's medical condition, shall be permitted to act as the Participant's authorized representative and will be notified of all approvals on the Claimant's behalf. In the event of an Adverse Benefit Determination, AvMed will notify both the Participant and the Heath Professional.

2.12 **Coinsurance** means the amount a Participant must pay once the Deductible has been met, if applicable, and is expressed as a percentage of the contracted rate for the covered benefit.

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

2.14 **Contract Year** means the period of 12 consecutive months commencing on the effective date of the Plan. **Benefit Period**, however, refers to a Calendar Year of January 1st through December 31st. Such Benefit Period will terminate on the earliest of the following dates:

2.14.01 the last day of each Calendar Year; or

2.14.02 the day the Participant ceases to be covered for health care benefits under the Plan.

2.15 **Core Benefits** means all benefits provided under Section VIII (SCHEDULE OF BASIC BENEFITS), subject to the limitations of Section IX (LIMITATIONS OF BASIC BENEFITS) and the exclusions of Section X (EXCLUSIONS FROM BASIC BENEFITS).

2.16 **Copayment** means the portion of the cost, in addition to the prepaid premium amounts, which the Participant is required to pay at the time certain health services are provided under the Plan. The Copayment may be a specific dollar amount or a percentage of the cost. The Participant is responsible for the payment of any Copayments directly to the provider of the health services at the time of service.

2.17 **Covered Dependent** means any Dependent of a Covered Employee who meets all applicable requirements of the Plan and is enrolled in the Plan.

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

2.19 **Custodial Care** means services and supplies that are furnished mainly to train or assist in the activities of daily living, such as bathing, feeding, dressing, walking and taking oral medications. 'Custodial Care' also means services and supplies that can be safely and adequately provided by persons other than licensed health professionals, such as dressing changes and catheter care, or that ambulatory patients customarily provide for themselves, such as ostomy care, administering insulin and measuring and recording urine and blood sugar levels.

2.20 **Deductible** means the first payments up to a specified dollar amount, excluding Copayments, which a Participant must make in the applicable Calendar Year for covered benefits. The Deductible applies to each Participant, subject to any family Deductible listed on the Schedule of Benefits. For purposes of

the Deductible, 'family' means the Covered Employee and Covered Dependents. The Deductible must be satisfied once each Calendar Year, except for:

2.20.01 **The Carryover provision**: if any part or all of the Deductible has been satisfied during the last three months of the preceding Calendar Year, the Deductible for the present Calendar Year will be reduced by the amount satisfied.

2.21 **Dental Care** means dental x-rays, examinations and treatment of the teeth or any services, supplies or charges directly related to:

2.21.01 the care, filling, removal or replacement of teeth, or

2.21.02 the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth, that are customarily provided by dentists (including orthodontics reconstructive jaw surgery, casts, splints and services for dental malocclusion).

2.22 **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

2.22.01 Serious jeopardy to the health of a patient, including a pregnant woman or fetus.

2.22.02 Serious impairment to bodily functions.

2.22.03 Serious dysfunction of any bodily organ or part.

2.22.04 With respect to a pregnant woman:

a. That there is inadequate time to effect safe transfer to another Hospital prior to delivery;

b. That a transfer may pose a threat to the health and safety of the patient or fetus; or

c. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

2.22.05 Examples of Emergency Medical Conditions include, but are not limited to: heart attack, stroke, massive internal or external bleeding, fractured limbs or severe trauma.

2.23 **Emergency Medical Services and Care** means medical screening, examination and evaluation by a Physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Physician to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, or surgery for a covered service by a Physician necessary to relieve or eliminate the Emergency Medical Condition within the service capability of the Hospital.

2.23.01 **In-area emergency** does not include elective or routine care, care of minor illness or care that can reasonably be sought and obtained from the Participant's Primary Care Physician. The determination as to whether or not an illness or injury constitutes an emergency shall be made by AvMed and may be made retrospectively based upon all information known at the time the patient was present for treatment.

2.23.02 **Out-of-area emergency** does not include care for conditions for which a Participant could reasonably have foreseen the need of such care before leaving the Service Area or care that could safely be delayed until prompt return to the Service Area. The determination as to whether or not an illness or injury constitutes an emergency shall be made by AvMed and may be made retrospectively based upon all information known at the time the patient was present for treatment.

2.24 **Employer** means City of Sunrise, 10770 W. Oakland Park Blvd, Sunrise, Florida, 33351. The Employer may also be referred to herein as the 'Plan Sponsor'.

2.25 **Essential Health Benefits** has the meaning under section 1302(b) of the Federal Act and applicable regulations. The ten categories of Essential Health Benefits are:

2.25.01 ambulatory patient services;

2.25.02 emergency services;

2.25.03 hospitalization;

2.25.04 laboratory services;

2.25.05 maternity and newborn care;

2.25.06 mental health and substance use disorder services (including behavioral health treatment);

2.25.07 pediatric services (including oral and vision care);

2.25.08 prescription drugs;

2.25.09 preventive and wellness services and chronic disease management; and

2.25.10 Rehabilitation and Habilitation Services and devices.

2.26 **Exclusion** means any provision of the Plan whereby coverage for a specific hazard or condition is entirely eliminated.

2.27 **Experimental and/or Investigational**. For the purposes of this Plan a medication, treatment, device, surgery or procedure may be determined by AvMed in its discretion, to be Experimental and/or Investigational if any of the following applies:

2.27.01 The FDA has not granted the approval for general use; or

2.27.02 There are insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

2.27.03 There is no consensus among practicing Physicians that the medication, treatment, therapy, procedure or device is safe or effective for the treatment in question or such medication, treatment, therapy, procedure or device is not the standard treatment, therapy, procedure or device utilized by practicing Physicians in treating other patients with the same or a similar condition; or

2.27.04 Such medication, treatment, procedure or device is the subject of an ongoing Phase I or Phase II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question. Notwithstanding the previous sentence, approved clinical trials, as such term is defined by Section 2709 of the Public Health Service Act ("PHSA") will not be treated as Experimental and/or Investigational if the requirements of Section 2709 of the PHSA are satisfied..

2.28 **Full-Time Student or Part-Time Student** means one who is attending a recognized and/or accredited college, university, vocational, or secondary school and is carrying sufficient credits to qualify as a Full-Time or Part-Time Student in accordance with the requirements of the school.

2.29 **Group Health Insurance** (for purposes of Section XI (COORDINATION OF BENEFITS) means that form of health insurance covering groups of persons under a master Group Health Insurance policy issued to any one of the groups listed in Sections 627.552 (employee groups), 627.553 (debtor groups), 627.554 (labor union and association groups), and 627.5565 (additional groups), *Florida Statutes*.

2.29.01 The terms 'amount of insurance' and 'insurance' include the benefits provided under a plan of self-insurance.

2.29.02 The term 'insurer' includes any person, entity or governmental unit providing a plan of self-insurance.

2.29.03 The terms 'policy', 'insurance policy', 'health insurance policy' and 'Group Health Insurance policy' include plans of self-insurance providing health insurance benefits.

2.30 **Habilitation Services** are services provided in order for a person to attain and maintain a skill or function never learned or acquired due to a disabling condition. They are services that are deemed necessary to meet the needs of individuals with developmental disabilities in programs designed to achieve objectives of improved health, welfare and the realization of individual's maximum physical, social, psychological and vocational potential for useful and productive activities.

2.30.01 Covered services consist of physical therapy, speech therapy, and occupational therapy that is provided for developmental delay, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder. Therapy services must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate state licensing board and must be furnished under the direction and supervision of a Physician or an advanced practice nurse in accordance with a written treatment plan established or certified by the treating Physician or advanced practice nurse.

2.30.02 Covered services take place in a participating non-residential setting separate from the home or facility in which the Participant lives.

2.30.03 Services are covered up to the point where no further progress can be documented. Services are not considered a covered benefit when measurable functional improvement is not expected or progress has plateaued.

2.30.04 Covered Habilitation Services do not include activities or training to which the Covered Employee may be entitled under federal or state programs of public elementary or secondary education or federally aided vocational rehabilitation.

2.30.05 Non-covered Habilitation Services include, but are not limited to: residential based Habilitation Services, home-based Habilitation Services, institutional based Habilitation Services, personal assistance/ attendant care services; errand services; transportation to and from training facilities unless provided by training facility; family education and training, family support services; prevocational services designed to assist a Participant in acquiring basic work skills; supportive employment habilitation; respite care/ camps/ hotel respite, room and board; services that are purely educational in nature, personal training or life coaching; Custodial Care (care that is provided primarily to assist in the activities of daily living, such as bathing, dressing, eating, and maintaining personal hygiene and safety and could be provided by people without professional skills or training).

2.31 **Health Professionals** means Physicians, osteopaths, podiatrists, chiropractors, physician assistants, nurses, social workers, pharmacists, optometrists, clinical psychologists, nutritionists, occupational therapists, physical therapists and other professionals engaged in the delivery of health care services, who are licensed and practice under an institutional license, individual practice association or other authority consistent with State law.

2.32 **Home Health Care Services (Skilled Home Health Care)** means services that are provided for a Participant who does not require confinement in a Hospital or Other Health Care Facility. Such services include, but are not limited to, the services of professional visiting nurses or other health care personnel for services covered under the Plan. A visit is limited to a period of two hours or less.

2.33 **Hospice** means a public agency or private organization that is duly licensed by the appropriate state entity to provide Hospice services and with whom AvMed has a current provider agreement. Such licensed entity must be principally engaged in providing pain relief, symptom management and supportive services to terminally ill Participants.

2.34 **Hospital** means a facility properly licensed pursuant to Chapter 395, *Florida Statutes* or if applicable, equivalent or similar laws of another state, that offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent. The term Hospital does not include: an Ambulatory Surgery Center; Skilled Nursing Facility; stand-alone Birthing Center; convalescent, rest or nursing home; or facility which primarily provides Custodial, educational or rehabilitative therapies.

2.34.01 If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Associate, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the score of covered services. It only expands the setting where covered services can be performed for coverage purposes.

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

2.35.01 generally and customarily provided by acute care general Hospitals in accordance with the standards of acceptable community practice;

2.35.02 performed, prescribed or directed by an Attending Physician; and

2.35.03 Medically Necessary for conditions which cannot be adequately treated in Other Health Care Facilities or with Home Health Care Services or on an ambulatory basis.

2.36 **Hospitalist/Admitting Panelist** means a Physician who specializes in treating inpatients and who may coordinate a Participant's health care when the Participant has been admitted for a Medically Necessary procedure or treatment at a Hospital.

2.37 **Injectable Medication** means 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, intra-articular injection, intracavernous injection or intraocular injection. Prior authorization is required for Injectable Medications.

2.38 **In-Network Provider** means any Health Professional (or group of Health Professionals), Hospital, Medical Office or Other Health Care Facility who is either under contract with the AvMed Network or with whom AvMed has established arrangements for providing these services as In-Network.

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

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

2.41 **Medically Necessary** means the use of any appropriate medical treatment, service, equipment and/or supply as provided by a Hospital, Skilled Nursing Facility, Physician or other provider which is necessary for the diagnosis, care and/or treatment of a Participant's illness or injury, and which is:

2.41.01 consistent with the symptom, diagnosis, and treatment of the Participant's condition;

2.41.02 the most appropriate level of supply and/or service for the diagnosis and treatment of the Participant's condition;

2.41.03 in accordance with standards of acceptable community practice;

2.41.04 not primarily intended for the personal comfort or convenience of the Participant, the Participant's family, the Physician or other health care providers;

2.41.05 approved by the appropriate medical body or health care specialty involved as effective, appropriate and essential for the care and treatment of the Participant's condition; and

2.41.06 not Experimental or Investigational.

2.42 **Medical Office** means any outpatient facility or Physician's office.

2.43 **Medical Services** (except as limited or excluded by the Plan) means those professional services of Physicians and other Health Professionals, including medical, surgical, diagnostic, therapeutic and preventive services that are:

2.43.01 generally and customarily provided in the geographic area; and

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

2.44 **Non-participating Provider** means any Health Professional or group of Health Professionals, Hospital, Medical Office or Other Health Care Facility with whom AvMed has neither made arrangements nor contracted to render the professional health services set forth herein as a Participating Provider. The Point of Service Plan provides access to Non-participating Providers as defined herein.

2.45 **Other Health Care Facility(ies)** means any licensed facility, other than acute care Hospitals and those facilities providing services to ventilator dependent patients, which provides inpatient services such as Skilled Nursing Care, Residential Treatment, and Rehabilitative Services.

2.46 **Out-of-Network Provider** means any Health Professional (or group of Health Professionals), Hospital, Medical Office or Other Health Care Facility who is neither under contract with the AvMed Network nor has AvMed established arrangements for providing these services as In-Network.

2.47 **Outpatient Rehabilitation Facility** means an entity, which renders, through providers properly licensed pursuant to Florida law or if applicable, equivalent or similar laws of another state outpatient physical, speech, occupational, and cardiac rehabilitation therapy for the primary purpose of restoring or improving bodily function impaired or eliminated a condition. The term Outpatient Rehabilitation Facility, as used herein, shall not include a Hospital, including a general acute care Hospital, or any separately organized unity of a Hospital which provides comprehensive medical rehabilitation inpatient services, or rehabilitation outpatient services, including, but not limited to, a Class III "specialty rehabilitation hospital" as described in Chapter 59A, *Florida Administrative Code*.

2.48 **Partial Hospitalization** means treatment in which an individual receives at least 7 hours of institutional care during a portion of a 24 hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered 'home' for purposes of this definition.

2.49 **Participant** means any Covered Employee or Covered Dependent as described in Sections 2.17 and 2.18 of this SPD.

2.50 **Participating Physician** means any Participating Provider licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes* or if applicable, equivalent or similar laws of another state.

2.51 **Participating Provider** means any Health Professional (or group of Health Professionals), Hospital, Medical Office or Other Health Care Facility with whom AvMed has made arrangements or contracted

to render the professional health services set forth herein, and at times shall be referred to as 'Plan Provider'.

2.52 **Plan** means the City of Sunrise Group Medical Plan sponsored by the Employer to provide covered Medical Services to Participants.

2.53 **Plan Administrator** means City of Sunrise, 10770 W. Oakland Park Blvd., Sunrise, Florida 33351, ATTENTION TO: Risk Management, Telephone: 954-572-2496.

2.54 **Post-Service Claim** means any Claim for benefits under the Plan that is not a Pre-Service Claim.

2.55 **Pre-Service Claim** means any Claim for benefits under the Plan for which (in whole or in part), a Participant must obtain authorization from AvMed in advance of such services being provided to or received by the Participant.

2.56 **Primary Care Physician** means any Physician engaged in family practice, pediatrics, internal medicine, obstetrics/gynecology, or any specialty Physician from time to time designated by AvMed as a 'Primary Care Physician' in AvMed's current list of Physicians and Hospitals.

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

2.58 **Rehabilitation Services** are Health Care Services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapies, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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

2.59.01 was relied upon in making a benefit determination;

2.59.02 was submitted, considered or generated in the course of making a benefit determination, without regard to whether it was relied upon in making the determination;

2.59.03 demonstrates compliance with the Plan's administrative process; and

2.59.04 constitutes a statement of policy or guidance with respect to the Plan concerning the Adverse Benefit Determination for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the Adverse Benefit Determination.

2.60 **Residential Treatment** is a 24-hour intensive structured and supervised treatment program providing an inpatient level of care but in a non-Hospital environment, and is utilized for those disorders that cannot be affectively treated in an outpatient or Partial Hospitalization environment.

2.61 **Service Area** means those counties in the State of Florida where AvMed has been approved to conduct business by the Agency for Health Care Administration (AHCA).

2.62 **Skilled Nursing Facility** means an institution or part thereof which is licensed as a Skilled Nursing Facility by the State of Florida, is accredited as a Skilled Nursing Facility by the Joint Commission or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare.

2.63 **Sound Natural Tooth** means a tooth that is whole or properly restored (restoration with amalgams only) and is not in need of the treatment provided for any reason other than an Accidental Dental Injury. For purposes of this Plan, a tooth previously restored with a crown inlay, onlay or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.

2.64 **Specialty Health Care Physician** means any Physician licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes*, (or if applicable, equivalent or similar laws of another state), other than the Participant's Primary Care Physician.

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

2.66 **Urgent Care Center** means a facility properly licensed to provide care for minor injuries and illnesses that require immediate attention, but are not severe enough for a trip to the emergency room, including cuts, sprains, eye injuries, colds, flu, fever, insect bites, and simple fractures. For purposes of this contract, an Urgent Care Center is not a Hospital, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

2.67 **Urgent Care Claim** means any Claim for medical care or treatment that could seriously jeopardize the Participant's life or health or the Participant's ability to regain maximum function or, in the opinion of a Physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment requested. Generally, the determination of whether a Claim is an Urgent Care Claim shall be made by an individual acting on behalf of AvMed applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. However, if a Physician with knowledge of the Participant's medical condition determines that the Claim is an Urgent Care Claim, it shall be deemed as such.

2.68 **Urgent Medical Condition** means a medical condition manifesting itself by acute symptoms that are of lesser severity than that recognized for an Emergency Medical Condition, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the illness or injury to place the health or safety of the Participant or another individual in serious jeopardy, in the absence of medical treatment within 24 hours. Examples of Urgent Medical Conditions include, but are not limited to: high fever, dizziness, animal bites, sprains, severe pain, respiratory ailments and infectious illnesses.

2.69 **Urgent Medical Services and Care** means medical screening, examination and evaluation in an ambulatory setting outside of a Hospital emergency department, including an Urgent Care Center, retail clinic or PCP office after-hours, on a walk-in basis and usually without a scheduled appointment; and the covered services for those conditions which, although not life-threatening, could result in serious injury or disability if left untreated.

2.70 **Utilization Management Program** means those comprehensive initiatives that are designed to validate medical appropriateness and to coordinate covered services and supplies. These include, but are not limited to:

2.70.01 concurrent review of all patients hospitalized in acute care, psychiatric, rehabilitation, and skilled nursing facilities, including on-site review when appropriate;

2.70.02 case management and discharge planning for all inpatients and those requiring continued care in an alternative setting (such as home care or a Skilled Nursing Facility) and for outpatients when deemed appropriate; and

2.70.03 the Benefit Coordination Program which is designed to conduct prospective reviews for select medical services to ensure that services are covered and Medically Necessary. The Benefit Coordination Program may also advocate alternative cost-effective settings for the delivery of prescribed care and may identify other options for non-covered health care needs.

2.71 **Ventilator Dependent Care Unit** means care received in any facility which provides services to ventilator dependent patients other than acute Hospital care, including all types of facilities known as

sub-acute care units, ventilator dependent units, alternative care units, sub-acute care centers and all other like facilities, whether maintained in a free standing facility or maintained in a Hospital or skilled nursing facility setting.

III. ELIGIBILITY

3.01 To be eligible to enroll as a Covered Employee, a person must be:

3.01.01 an employee of the City of Sunrise who works the required number of hours per week, and is employed for the waiting period required for eligibility, or a retiree.

3.01.02 entitled on his own behalf to participate in the medical and Hospital care benefits provided by the City of Sunrise under the Plan. Coverage begins the first day of the month following the waiting period.

3.02 To be eligible to enroll as a Covered Dependent, a person must be:

3.02.01 the spouse of the Covered Employee (a new spouse must be enrolled within 31 days after marriage in order to be covered); or

3.02.02 a child of the Covered Employee, or a child of a Covered Dependent of the Covered Employee, provided that all of the following conditions apply:

a. The child is under the age of 26; and

b. The natural child or stepchild of the Covered Employee; or

c. A legally adopted child in the custody of the Covered Employee from the time of placement in the home (written evidence of adoption must be furnished to the Employer upon request); or

d. A child for whom the Covered Employee has been appointed legal guardian pursuant to a valid court order. In the event an eligible Dependent child does not reside with the Subscriber, coverage will be extended where the Subscriber if obligated to provide medical care by Qualified Medical Child Support Order (QMCSO). You (or your beneficiaries) may obtain, without charge, copies of the Plan's procedures governing QMCSOs and a sample QMCSO by contacting the Plan Administrator; or

e. The newborn child of a Covered Dependent of the Covered Employee other than the spouse of the Covered Employee (such coverage terminates 18 months after the birth of the newborn child).

With respect to 3.02.02 (a), coverage for a child of a Covered Employee will end at the end of the month in which they reach the age 26. Children up to age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer.

3.02.03 In the case of a newborn child, the Covered Employee should notify the Employer of the intention to enroll the newborn child, and provide any documentation as may be required, not later than 31 days after the birth. If timely notice is provided, no additional premium will be charged for the additional coverage of the newborn during the 31-day period following the birth of the child. If timely notice is not provided, the additional premium for the additional coverage of the newborn child will be charged from the child's date of birth. If notice is not provided within 60 days of the birth, the child may not be enrolled until the next open enrollment period of the Plan.

3.02.04 All services applicable for Covered Dependent children under the Plan shall be provided to an enrolled newborn child of the Covered Employee; to the enrolled newborn child of a Covered Dependent of the Covered Employee; or to the newborn adopted child of the

Covered Employee, provided that a written agreement to adopt such child has been entered into (prior to the birth of the child) from the moment of birth (as provided in Section 8.22). In the case of the newborn adopted child, coverage shall not be effective if the child is not ultimately placed in the Covered Employee's residence, in compliance with Florida law.

3.02.05 In the event the Covered Employee has a child who meets the following requirements, extended coverage may be available for that child until the end of the Calendar Year in which the child reaches age 30:

a. The child is unmarried and does not have a Dependent of his or her own;

b. The child is a resident of Florida or a Full-Time or Part-Time Student; and

c. The child is not provided coverage as a named Participant, insured, or enrollee under any other group, blanket or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

3.02.06 It is the Participant's responsibility to notify the Employer when the child no longer meets the eligibility requirements of Section 3.02. Termination of coverage may be retroactively applied if the Employer is not notified within 31 days. Participant agrees to provide supporting documentation upon request by AvMed or Employer.

3.02.07 No person is eligible to enroll hereunder who has had his coverage previously terminated under Section 7.01.03, except with the written approval of AvMed.

3.02.08 Attainment of the limiting age by a Dependent child shall not operate to exclude from or terminate the coverage of such child, while such child is and continues to be both:

a. incapable of self-sustaining employment by reason of mental retardation or physical handicap; and

b. chiefly dependent upon the Participant for support and maintenance, provided proof of such incapacity and dependency is furnished to the Employer by the Participant within 31 days of the child's attainment of the limiting age, and subsequently as may be required by the Employer, but not more frequently than annually after the 2-year period following the child's attainment of the limiting age.

3.03 During the Contract Year, no changes in the Plan's eligibility or requirements of participation shall be permitted to effect eligibility or enrollment under the Plan unless such change is required by law or agreed to by AvMed.

3.04 If the child of a Covered Employee is enrolled in the Plan on the basis of being a student at a postsecondary educational institution immediately before the first day of a medically necessary leave of absence, the Plan will not terminate the coverage of such child before the earlier of (1) one year after the first day of the medically necessary leave of absence, or (2) the date on which such coverage would otherwise terminate under the terms of the Plan. A "medically necessary leave of absence" is a leave of absence (or any other change in enrollment), from a postsecondary educational institution that (1) begins while the child is suffering from a severe illness or injury, (2) is medically necessary, and (3) causes the child to lose student status under the terms of the Plan. Certification by the child's Attending Physician must be submitted to the Plan stating that the child is suffering from a severe illness or injury and that the leave of absence or other change of enrollment is medically necessary. A child whose benefits are continued under this provision is entitled to the same benefits as if (during the medically necessary leave of absence) the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

IV. ENROLLMENT

4.01 Prior to the effective date of the Plan and at a proper time prior to each anniversary thereof, the Employer may allow an open enrollment period of 31 days in which any eligible employee on behalf of himself and his eligible Dependents may elect to enroll in the Plan.

4.02 Except as provided for newborns, eligible employees and Dependents who meet the eligibility requirements of Section III (ELIGIBILITY) outside of the annual open enrollment period and who qualify for a special enrollment period pursuant to Section 4.03, must enroll within 31 days after becoming eligible by submitting application forms acceptable to or provided by AvMed; otherwise, the eligible employees and Dependents may not enroll until the next open enrollment period of the Employer.

4.03 Special enrollment periods. Eligible employees and their eligible Dependents may request to enroll in the Plan outside of the initial enrollment period and annual open enrollment periods if that individual loses other coverage or acquires a new Dependent as outlined below.

4.03.01 If the eligible employee or Dependent declined coverage under the Plan when it was first offered because of other group medical plan or insurance coverage, and such other coverage has terminated as a result of:

a. exhaustion of COBRA continuation coverage;

b. termination of employment or reduction in hours of employment;

c. termination of employer contributions;

d. legal separation, divorce or annulment;

e. change in Dependent status;

f. death of the employee;

g. change in legal custody or legal guardianship; or

h. relocation out of an HMO service area.

4.03.02 If the eligible or Covered Employee acquires a new Dependent as a result of:

a. marriage;

b. birth; or

c. adoption or placement for adoption.

4.03.03 In the event of 4.03.01 or 4.03.02 above, a completed Enrollment or Status Change Form (together with proof of the qualifying event under 4.03.01) must be submitted within 31 days of the date of termination of other coverage; or within 31 days of the date the Dependent becomes eligible; or within 60 days as required for newborns. To enroll an eligible Dependent, the eligible employee must also enroll or already be a Participant.

4.03.04 Eligible employees and Dependents who are not enrolled, shall be eligible to enroll for coverage within 60 days following:

a. termination of coverage under Medicaid or Children's Health Insurance Plan (CHIP) due to loss of eligibility; or

b. determination of eligibility for premium assistance under Medicaid or CHIP.

c. A completed Enrollment or Status Change Form must be submitted within 60 days of the date of the termination of Medicaid or CHIP coverage; or within 60 days of the date of determination of eligibility for premium assistance under Medicaid or CHIP. To

enroll an eligible Dependent, the eligible employee must also enroll or already be a Participant.

4.03.05 Termination resulting from failure to pay premiums on a timely basis or termination of coverage for cause (due to fraud, intentional misrepresentation, etc.) will not provide a special enrollment period.

4.04 The eligibility requirements set forth in Section III (ELIGIBILITY) shall at all times control and no coverage contrary thereto shall be effective. Coverage shall not be implied due to clerical or administrative errors if such coverage would be contrary to Section III (ELIGIBILITY).

V. EFFECTIVE DATE OF COVERAGE

5.01 Subject to the payment of applicable monthly administrative fees, coverage under this Plan shall become effective on the following dates:

5.01.01 Eligible employees and their eligible Dependents that enroll during the open enrollment period will become Participants as of the effective date of this Plan or subsequent anniversary thereof.

5.01.02 If a Participant acquires an eligible Dependent through birth, adoption, placement for adoption or marriage, such Dependent shall be treated as covered under the Plan if, within 31 days (or 60 days as provided for newborns in Section III (ELIGIBILITY) of acquiring the new Dependent, the Participant completes and submits an enrollment form on behalf of such Dependent. If the enrollment form is received by the Employer within the 31 day time period (or 60 days as provided for newborns), the enrollment for such Dependent shall become effective on the date of the birth, adoption or placement for adoption; or in the case of marriage, on the date of marriage. During this period, eligible employees and their eligible Dependents may also enroll for medical coverage under the Plan, if not already covered. However, if an enrollment request is not received by the Employer within the required time frame, the employee and Dependents will be required to wait until the next open enrollment period to apply for coverage.

5.01.03 Coverage for the newborn child of a Covered Employee or the newborn child of a Covered Dependent is effective at birth if Sections 3.02.03 and 5.01.02 are complied with.

5.01.04 If an eligible employee or the employee's eligible Dependents originally declined medical coverage under the Plan due to other health coverage, and that coverage is subsequently terminated as a result of either a loss of eligibility for such coverage or the termination of any employer contributions for such coverage, or termination of the Plan, the employee and the employee's Dependents will be eligible to enroll in the Plan. To enroll, a completed Enrollment Form must be submitted within 31 days of the date of termination of other coverage. The effective date of any coverage provided under the Plan will be the day following the loss of other coverage. If the employee fails to enroll within 31 days after the loss of other coverage, the employee and the employee's Dependents must wait until the next open enrollment period to apply for coverage, absent eligibility for a second special enrollment period.

5.01.05 If an employee or the employee's Dependents are eligible for coverage but not enrolled, and experience a termination of coverage under Medicaid or CHIP due to loss of eligibility, or are determined to be eligible for premium assistance under Medicaid or CHIP, the employee and the employee's Dependents will be eligible to enroll in the Plan. To enroll, a completed Enrollment Form must be submitted within 60 days of the date of the termination of coverage or the determination of eligibility for assistance. The effective date of any coverage provided by AvMed will be the first day of the month following the date of enrollment. If the

employee fails to enroll within 60 days after the loss of such coverage or the determination of such eligibility, the employee and the employee's Dependents must wait until the next open enrollment period to apply for coverage, absent eligibility for a second special enrollment period.

VI. MONTHLY PAYMENTS AND COPAYMENTS

6.01 **Annual maximum out-of-pocket limits** (as described in your Schedule of Benefits). The Deductible, as well as any Coinsurance and Copayments you pay for covered benefits received during any Calendar Year are accumulated toward your annual maximum out-of-pocket limit. Amounts paid as penalties do not count toward any Deductible or out-of-pocket limits. Once you meet your individual or family annual maximum out-of-pocket limit in any Calendar Year, the Plan will pay 100% of the allowable charges for all covered services for the remainder of that Calendar Year. It is the responsibility of the Participant to retain receipts and to notify and document to the satisfaction of the Plan when the annual maximum out-of-pocket limits have been reached.

Expenses that do not count toward the annual maximum out-of-pocket expense limit are (i) expenses related to charges for services not covered including charges exceeding the Maximum Allowable Payment, (ii) additional charges incurred for failure to pre-authorize a service requiring prior authorization, (iii) expenses that relate to services that exceed any specific treatment Limitations noted in the Schedule of Benefits, and (iv) Brand Additional Charges for Prescription Medications.

6.02 A Participant will be entitled to covered benefits after the Participant has satisfied the Deductible amount specified on the Schedule of Benefits. After satisfying the Deductible, the Participant must pay any applicable Copayments or Coinsurance for covered benefits. Covered benefits to which the Deductible applies are shown in the Schedule of Benefits.

6.03 In the event of the retroactive termination of a Participant, neither the Plan nor AvMed shall be responsible for medical expenses incurred by the Plan in providing benefits to the Participant under the terms of the Plan after the effective date of termination.

VII. TERMINATION OF PARTICIPATION

7.01 **Reasons for Termination**

7.01.01 **Loss of eligibility**

a. Upon the loss of a Participant's eligibility, as defined in Section III (ELIGIBILITY), coverage will either (i) terminate immediately, if AvMed and/or the Employer so elects, in their sole discretion, or (ii) automatically terminate on the last day of the month for which the monthly administrative fee was paid and during which the Participant was eligible for coverage if no election is made under (i) above.

b. Upon a loss of the Covered Employee's eligibility, as defined in Section III (ELIGIBILITY), coverage for all Covered Dependents will either (i) terminate immediately if AvMed and/or the Employer so elects, in their sole discretion, or (ii) automatically terminate on the last day of the month during which the Covered Dependent was eligible for coverage if no election is made under (i) above.

7.01.02 **Failure to pay Copayments and fees**

a. Upon failure of the Employer to make payment of the monthly administrative fee within 30 days following the due date specified by AvMed, benefits under the Plan shall terminate for all Participants for whom such payment has not been received at 12:00 am (midnight) on the last day of the month for which the monthly administrative fee was paid.

b. Upon failure of a Covered Employee to make payment of any contributions or applicable supplemental charges required under Section VI (MONTHLY PAYMENTS AND COPAYMENTS), the Employer and AvMed reserve the right to terminate coverage for the Covered Employee and all Covered Dependents on the tenth day after written notice from AvMed or the Plan.

7.01.03 **Termination of participation for cause**. AvMed may terminate or cease to provide services to any Participant immediately upon written notice for the following reasons which lead to a loss of eligibility of the Participant:

a. Fraud, material misrepresentation or omission in applying for participation, benefits or coverage under the Plan. However, relative to a misstatement in the Application, after two years from the issue date, only fraudulent misstatements in the Application may be used to void the policy or deny any claim for a loss occurred or disability starting after the two year period;

b. Misuse of the Plan's identification card furnished to the Participant;

c. Furnishing to the Plan or AvMed incorrect or incomplete information for the purpose of obtaining participation, coverage or benefits under the Plan; or

d. Behavior which is disruptive, unruly, abusive or uncooperative to the extent that the Participant's continuing coverage under the Plan seriously impairs AvMed's ability to administer the Plan or to arrange for the delivery of health care services to the Participant or other Participants after AvMed has attempted to resolve the Participant's problem.

e. At the effective date of such termination, administrative service fee payments received by AvMed on account of such termination shall be refunded on a pro rata basis, and AvMed shall have no further liability or responsibility for the Participant(s) under the Plan.

7.02 **Notification requirements**:

7.02.01 **Loss of eligibility of Covered Employee**. It is the responsibility of the Employer to notify AvMed in writing within 31 days from the effective date of termination regarding any Covered Employee and/or Covered Dependent who becomes ineligible to participate in the Plan. Employer shall be liable for claims incurred by Covered Employees or Covered Dependents resulting from failure of Employer to provide such timely notification.

7.02.02 **Loss of eligibility of Covered Dependent**. When a Covered Dependent becomes ineligible for coverage, the Covered Employee is required to notify the Plan Administrator in writing within 31 days of the Covered Dependent becoming ineligible.

7.03 **Continuation Coverage under COBRA**. COBRA requires that most employers sponsoring group health plans offer certain employees and former employees their eligible Dependents the opportunity for a temporary extension of health coverage (called 'continuation coverage') at group rates in certain instances where coverage under the Plan would otherwise end. This section of the SPD is intended to inform Participants, in a summary fashion, of their rights and obligations under the continuation coverage provisions of the law. Participants should take the time to read this section carefully.

7.03.01 **Eligibility**. Covered Employees or their Covered Dependents will become eligible for continuation coverage under COBRA after any of the following qualifying events result in the loss of Plan coverage:

a. Loss of benefits due to a reduction in the Covered Employee's hours of employment;

b. Termination of the Covered Employee's employment including retirement but excluding termination for gross misconduct; or

c. Termination of employment following leave under the Family and Medical Leave Act of 1993 (FMLA), in which case the qualifying event will occur on the earlier of the date the Covered Employee indicates he will not return to work or the last day of the FMLA leave.

d. In addition, Covered Dependents will become eligible for COBRA continuation coverage after any of the following qualifying events occur to cause a loss of Plan coverage:

   i. The Covered Employee's death;

   ii. Divorce, legal separation from the Covered Employee;

   iii. The Covered Employee first becomes entitled to and enrolls in Medicare; or

   iv. The Covered Dependent child no longer qualifies as an eligible Dependent under the Plan.

e. A child who is born to (or placed for adoption) with a covered former employee during the continuation coverage period has the same continuation coverage rights as an eligible Dependent child described above.

7.03.02 **Notification**. If a qualifying event other than divorce, legal separation, loss of eligible Dependent status or entitlement to Medicare occurs, the Employer will notify AvMed and its COBRA Administration business partner, of the qualifying event, who will send the Covered Employee an election form. To continue Plan coverage, the completed election form must be returned to AvMed's COBRA Administrator business partner within 60 days after the date the form is received, or the date the Covered Employee's coverage ends due to the qualifying event.

a. If divorce, legal separation, loss of eligible Dependent status or entitlement to Medicare under the Plan occurs, the Covered Employee or Covered Dependent is responsible for notifying the Plan Administrator that a qualifying event has occurred. Such notice must be received by the Plan Administrator within 60 days after the later of the date of such event, or the date the Participant would lose coverage on account of such event. Failure to timely notify the Plan Administrator of these events will result in loss of the right of a Participant to continue coverage.

b. After receiving such notice, the Plan Administrator will notify AvMed and its COBRA Administration business partner, who will send the Participant an election form within 14 days. If the Participant wishes to elect continuation coverage, the election form must be returned completed to the AvMed's COBRA Administration business partner within 60 days from the later of the date the form is received or the date coverage ends due to the qualifying event.

7.03.03 **Cost**. If continuation coverage is elected, Participants must pay the entire cost of coverage (the employer's contribution and the active employee portion of the contribution), plus a 2% administrative fee for the duration of COBRA continuation coverage.

a. If a Covered Employee or Covered Dependent is Social Security disabled (Social Security disability status must occur as defined by Title II or Title XVI of the Social Security Act), the Covered Employee may elect continuation coverage for the disabled person only or for some or all COBRA eligible family members for up to 29 months if the Covered Employee's employment is terminated or hours are reduced. The Covered Employee must pay 102% of the cost of coverage for the first 18 months of COBRA

continuation coverage and 150% of the cost of coverage for the 19th through the 29th months of coverage. The Social Security disability date must be determined to have occurred within the first 60 days of loss of coverage due to termination of the Covered Employee's employment or reduction in hours.

b. For COBRA coverage to remain in effect, payment must be received by the Plan Administrator by the first day of the month for which the premium is due (the first payment is due no later than 45 days after the election to continue coverage, and must cover the period of time back to the first day of COBRA continuation coverage).

7.03.04 **Duration**. COBRA Continuation Coverage can be continued for up to:

a. **18 months** if coverage ended due to a reduction in a Covered Employee's work hours or termination of employment and the Covered Employee or one of his Covered Dependents is not Social Security disabled within 60 days of the date of the loss of coverage due to termination of employment or reduction in hours. If the Covered Employee becomes entitled to Medicare during the course of this initial 18 months of coverage, the Covered Dependents may elect to extend COBRA for an additional 18 months; or

b. **36 months** for Covered Dependents, if the Covered Dependents lose eligibility for medical coverage due to the Covered Employee's death, divorce or legal separation from the Covered Employee, the Covered Employee's entitlement to Medicare after termination or reduction in hours, or the Covered Employee's Covered Dependent child ceasing to qualify as an eligible Dependent under the Plan; or

c. **29 months** if the Covered Employee's coverage is lost due to termination of employment or reduction in hours and the Covered Employee or Covered Dependent is disabled, as defined by Title II or Title XVI of the Social Security Act, within 60 days of the original qualifying event. In this case, the Covered Employee may continue coverage for an additional 11 months after the original 18-month period either for the disabled person only or for one or all of the Covered Dependents.

   i. To be eligible for extended coverage due to Social Security disability, a Covered Employee must notify the Plan Administrator of the disability before the end of the initial 18 months of COBRA continuation coverage and within 60 days following the date the Covered Employee or Covered Dependent is determined to be disabled by the Social Security Administration. If the disabled individual should no longer be considered to be disabled by the Social Security Administration, the Covered Employee must notify the Plan Administrator within 30 days following the end of the disability. Coverage that has exceeded the original 18-month continuation period will end when the individual is no longer Social Security disabled.

d. If more than one qualifying event occurs, no more than 36 months total of COBRA continuation coverage will be available. The COBRA beneficiary must experience the second qualifying event during the first 18 months of COBRA continuation, and must provide notice to the Plan Administrator within the required time period. COBRA continuation coverage will end sooner if the Plan terminates and the employer does not provide replacement medical coverage, or if a person covered under COBRA:

   i. first becomes covered under another group health plan after the loss of coverage due to a termination or reduction in hours, this Plan will be secondary for all eligible health care expenses, provided contributions for COBRA coverage continue to be paid. Coverage may only continue for the remainder of the original COBRA period;

ii. fails to make required contributions when due;

iii. first becomes entitled to Medicare benefits after the initial COBRA qualifying event; or

iv. is extending the 18-month coverage period because of disability and is no longer disabled as defined by the Social Security Act.

7.04 **Continuation Coverage during leaves of absence**.

7.04.01 **Family and Medical Leaves of Absence (FMLA)**. Under FMLA, a Covered Employee may be entitled to up to a total of 12 weeks of unpaid job-protected leave during each Calendar Year for the following:

a. the birth of the Covered Employee's child, to care for the newborn child, or for placement of a child in the Covered Employee's home for adoption or foster care;

b. to care for a spouse, child or parent with a serious health condition; or

c. for the Covered Employee's own serious health condition.

d. If the FMLA leave is paid, such pay will be reduced by the amount of the Covered Employee's before-tax contributions as usual for the coverage level in effect on the date FMLA leave begins. If FMLA leave is unpaid, the Covered Employee will be required to pay contributions directly to the employer until returning to active pay status.

e. If the Covered Employee notifies the employer that he is terminating employment during FMLA leave, coverage will end on the date of notification. If the Covered Employee does not return to work on the expected FMLA return date, and the employer is not notified of the intent either to terminate employment or to extend the period of leave, coverage will end on the date the Covered Employee was expected to return.

f. Plan elections may not be changed during FMLA leave unless an open enrollment occurs or the Covered Employee has a change in status event or a special enrollment event under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

7.04.02 **Military leaves of absence**. If a Covered Employee is absent from work due to military service, continuation coverage under the Plan (including coverage for enrolled Dependents) may be elected for up to 18 months from the first day of absence (or if earlier, until the day after the date the Covered Employee is required to apply for or return to active employment with the employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). The Covered Employee's contributions for continued coverage will be the same as for similarly situated active participants in the Plan.

a. Whether or not coverage is continued during military service, a Covered Employee may reinstate coverage under the Plan option elected on return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that any required waiting period was not completed prior to the start of the military service.

VIII. SCHEDULE OF BASIC BENEFITS

AvMed is committed to arranging for comprehensive prepaid health care services rendered to Participants through AvMed's network of contracted independent Physicians and Hospitals and other independent health care providers, under reasonable standards of quality health care. The professional judgment of a Physician licensed under Chapter 458 (physician), 459 (osteopath), 460 (chiropractor) or 461 (podiatrist), *Florida Statutes*, or if applicable, equivalent or similar laws of another state, concerning the proper course of treatment for a Participant shall not be subject to modification by AvMed or its Board of Directors, Officers or Administrators.

However, this Section is not intended to and shall not restrict any Utilization Management Program established by AvMed.

Participants are entitled to receive the covered services and benefits through the AvMed Network or from providers with whom AvMed has either contracted or made arrangements (known as In-Network Providers), or from providers with whom AvMed has not contracted or made arrangements (known as Out-of-Network Providers). The Point of Service Plan creates two benefit payment levels; one for services provided by In-Network providers and a second for services provided by Out-of-Network Providers. The Benefit Level this Plan will pay depends on the Health Professional and/or facility you select to provide covered health care services and where the services are received:

- If the Health Professional and/or facility used is part of the AvMed Network or other contracted network arrangements, benefits for covered services are payable at the Participating Provider In-Network Benefit Level shown in the Schedule of Benefits.
- If the Health Professional and/or facility used is an Out-of-Network Provider, benefits for covered services are payable at the Out-of-Network Benefit Level as specified in the Schedule of Benefits.

An important feature of this Point of Service Plan is that the amount of your out-of-pocket expense is determined by your choice of provider at the time services are sought:

- Participants choosing In-Network Providers will be responsible for paying lower Deductibles, Copayments and/or Coinsurance.
- Participants choosing Out-of-Network Providers will pay the highest Deductibles and Coinsurance amounts and will also be at risk for provider fees that are in excess of allowed amounts. In other words, a Participant who chooses an Out-of-Network Provider may be responsible to pay the amount that exceeds the Maximum Allowable Payment for the particular medical service involved, in addition to the applicable Deductible and Coinsurance amounts. Also, fees that are in excess of allowed amounts are not a covered benefit and therefore do not apply to your Deductible or annual out-of-pocket limit.

It is the Participant's responsibility when seeking benefits under the Plan to identify himself as a Plan Participant and to verify that the provider chosen is still a contracted provider of the selected network. Participants should confirm participation of a selected provider prior to seeking services.

Any Participant requiring medical, Hospital, or ambulance services for emergencies (as described in Sections 2.22 and 2.23), while outside the Service Area or within the Service Area, but before they can reach a Participating Provider, may receive the emergency benefits as specified in Section 8.12.

Only services and benefits in conformity with Section II (DEFINITIONS), Section VIII (SCHEDULE OF BASIC BENEFITS), Section IX (LIMITATIONS OF BASIC BENEFITS), Section X (EXCLUSIONS FROM BASIC BENEFITS) and the Schedule of Benefits, which by reference is incorporated herein, are covered by the Plan. Participants must understand that services will not be covered if they are not, in AvMed's opinion, Medically Necessary. Any and all decisions made by AvMed in administering the provisions of this Contract, including without limitation, the provisions of Section VIII (SCHEDULE OF BASIC BENEFITS), Section IX (LIMITATIONS OF BASIC BENEFITS) and Section X (EXCLUSIONS FROM BASIC BENEFITS) are made only to determine whether payment for any benefits will be made by the Plan.

Any and all decisions that pertain to the medical need for, or desirability of, the provision or non-provision of Medical Services or benefits, including without limitation, the most appropriate level of such Medical Services or benefits, must be made solely by the Participant and his Physician in accordance with the normal patient/Physician relationship for purposes of determining what is in the best interest of the Participant. AvMed does not have the right of control over the medical decisions made by the Participant's Physician or health care providers. The ordering of a service by a Physician, whether participating or non-participating, does not in itself make such service Medically Necessary. The Employer and Participants acknowledge that it is possible that a Participant and his Physician may determine that such services or supplies are appropriate even though such

services or supplies are not covered and will not be arranged or paid for by the Plan. Any covered service for which the Participant is seeking reimbursement, must be submitted to AvMed within one year from the date of service to be considered.

Cost-Sharing Information

Deductible. In some instances, the annual Deductible specified in the Schedule of Benefits must be satisfied before the Plan will begin paying expenses for services covered. The Deductible means the amount a Participant must pay each Calendar Year for covered services before the Plan will make payment for eligible expenses. The individual Deductible or family Deductible must be satisfied each Calendar Year before any payment for certain services and medications will be made by the Plan for any Claim.

Any eligible expenses credited by the Plan toward the Deductible requirement during the last three months of the Plan's prior Calendar Year, will be reduced to the extent of such application for the present Calendar Year. Only those eligible expenses submitted on Claims to AvMed will be credited toward the Deductible. Expenses that are not eligible expenses will not be counted toward the satisfaction of the Deductible.

Coinsurance. Once the Calendar Year Deductible has been met, Participants are responsible for paying a percentage of eligible expenses. The coverage percentage, hereinafter called 'Coinsurance' is specified in the Schedule of Benefits. Participants will be responsible for paying any charges not considered an eligible expense.

Deductible Carryover. Any expenses incurred by a Participant 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 this 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 Plan; and
- the expenses would be considered eligible expenses under this Plan.

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

Prior authorization of Covered Services

Services that require prior authorization from AvMed include, but are not limited to:

- All non-emergency inpatient admissions (including but not limited to Hospital and observation stays, skilled nursing facilities, ventilator dependent care and/or acute rehabilitation)
- All Home Health Care Services
- Complex diagnostic testing, therapeutic, and sub-specialty procedures (including but not limited to CT, CTA, MRI, MRA, PET Scans, Nuclear Cardiac Studies, Nuclear Medicine, and Radiation Oncology)
- Surgical procedures or services performed in an outpatient Hospital, Hospital-affiliated ambulatory surgery center
- All medications administered in an outpatient Hospital or infusion therapy setting
- Select medications administered in a Physician's office
- Transplant services
- Dialysis services

Services requiring prior authorization may change from time to time. For more information about which services require prior authorization, contact AvMed at 1-844-263-2369, or visit www.avmed.org.

If a Physician is an AvMed Network provider, he or she will handle all authorizations, notifications and utilization reviews with AvMed. If a Physician is not an AvMed Participating Provider, Participants are responsible for making sure the Physician or Health Professional contacts AvMed to obtain prior authorization

for a covered service when it is required. Participants should refer to their Plan identification card for the telephone number where authorization may be obtained, or have the Physician call 1-844-263-2369.

Please remember that failure to obtain prior authorization of a service will result in a denial of claims, or a reduction in coverage to 50% coinsurance after applicable Deductible. This denial or reduction will occur regardless of whether such services are deemed Medically Necessary. If an inpatient admission is extended beyond the number of days approved without authorization, benefits for the extra days will be denied.

AvMed encourages but does not require Participants to select a Primary Care Physician (PCP) upon enrollment. For children, Participants may designate a pediatrician as the PCP. Participants have the right to designate any PCP who participates in our network and who is available to accept you or your family members. The selection of a PCP can be changed at any time. For information on how to select a PCP, and for a list of the participating PCPs, contact AvMed. The names and addresses of Participating Providers and Hospitals are set forth in a separate booklet which, by reference, is made a part hereof. The list of Participating Providers, which may change from time to time, will be provided to the Employer. The list of Participating Providers may also be accessed from the AvMed Website at www.avmed.org. Notwithstanding the printed booklet, the names and addresses of Participating Providers on file with AvMed at any given time shall constitute the official and controlling list of Participating Providers.

Health Professionals may from time to time cease their affiliation with AvMed or another contracted network arrangement. In such cases, Participants will be required to receive services from another participating Health Professional, subject to continuity of care rules to the extent required by law, in order to continue to receive benefits at the In-Network Benefit Level.

PARTICIPANTS ARE RESPONSIBLE AND WILL BE LIABLE FOR COPAYMENTS, DEDUCTIBLES AND/OR COINSURANCE WHICH MUST BE PAID TO HEALTH CARE PROVIDERS FOR CERTAIN SERVICES, AT THE TIME SERVICES ARE RENDERED, AS SET FORTH IN THE SCHEDULE OF BENEFITS. THE SCHEDULE OF BENEFITS IS A SEPARATE DOCUMENT AVAILABLE FROM THE PLAN ADMINISTRATOR OR AVMED'S MEMBER SERVICES AND IS INTENDED TO ACCOMPANY THIS SPD IN EXPLAINING THE BENEFITS AVAILABLE UNDER THE PLAN.

8.01 **Ambulance services** as follows:

8.01.01 Local professional air/ground ambulance transport for emergency services to the nearest emergency department appropriately staffed and equipped to treat a medical condition;

8.01.02 Ground transportation to an alternative level of care when associated with an approved Hospital confinement; and

8.01.03 Ground transportation to a Participant's home will be covered when associated with an approved hospitalization or other confinement and the Participant's condition requires the skill of medically trained personnel. Transportation is not covered when the skill of medically trained personnel is not required and the Participant can be safely transferred (or transported) by other means.

8.01.04 Air ambulance transportation is covered only when the point of pick-up is inaccessible by land or when distance or other obstacles are involved in transporting the Participant to the nearest emergency department equipped to adequately treat the medical condition.

8.02 **Cardiac rehabilitation**. Cardiac rehabilitation is covered for the following conditions: acute myocardial infarction, percutaneous transluminal coronary angioplasty (PTCA), coronary artery bypass graft (CABG), repair or replacement of heart valves or heart transplant. Coverage is limited to a maximum of 18 visits per Calendar Year.

8.03 **Clinical trials.** Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

8.03.01 cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

8.03.02 cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as AvMed determine, a clinical trial meets the qualifying clinical trial criteria stated below.

8.03.03 Surgical musculoskeletal disorders of the spine, hip and knees, which are not life-threatening, for which AvMed determines a clinical trial meets the qualifying clinical trial criteria stated below.

8.03.04 Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial. Benefits are available only when the Participant is clinically eligible for participation in the qualifying clinical trial as defined by the researcher. Participants are required to use a Participating Provider for any clinical trials covered under this Summary Plan Description.

8.03.05 Routine patient care costs for qualifying clinical trials include:

a. Covered Health Services for which benefits are typically provided absent a clinical trial;

b. Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications;

c. Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

8.03.06 Routine costs for clinical trials do not include:

a. The Experimental or Investigational service or item. The only exceptions to this are:

i. certain Category B devices;

ii. certain promising interventions for patients with terminal illnesses;

iii. other items and services that meet specified criteria in accordance with our medical and drug policies.

b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

d. Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

8.03.07 With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the list below. With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees which are not life threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the list below.

a. Federally funded trials. The study or investigation is approved or funded by (which may include funding through in-kind contributions) by one or more of the following:

i. National Institutes of Health (NIH). (Includes National Cancer Institute.)

ii. Centers for Disease Control and Prevention.

iii. Agency for Healthcare Research and Quality.

iv. Centers for Medicare and Medicaid Services.

v. A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veteran's Administration.

vi. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.

vii. The Department of Veteran Affairs, the DOD, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:

(a) Comparable to the system of peer review of studies and investigations used by the NIH.

(b) Ensures unbiased review of the highest scientific standard by qualified individuals who have no interest in the outcome of the review.

b. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.

c. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

d. The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards before participants are enrolled in the trial. AvMed may, at any time, request documentation about the trial.

e. The subject or purpose of the trial must be the evaluation or an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

8.04 **Coverage for cleft lip and cleft palate** for Participants under 18 years of age. The coverage provided by this Section is subject to the terms and conditions applicable to other benefits.

8.05 **Dermatological services**. AvMed will cover office visits to a dermatologist for Medically Necessary covered services subject to Sections 2.41 and 2.68. No prior referral is required for these services.

8.06 **Diabetes treatment** includes all Medically Necessary equipment, supplies, and services to treat diabetes. This includes outpatient self-management training and educational services if the Participant's Primary Care Physician or the Physician to whom the Participant has been referred who specializes in diabetes treatment certifies the equipment, supplies or services are Medically Necessary. Insulin pumps are covered under Section 8.11. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board certified endocrinologist.

8.07 **Diabetic supplies**. Insulin, insulin syringes, lancets, and test strips are covered under the supplemental prescription medication benefits.

8.08 **Diagnosis and treatment of Autism Spectrum Disorder** through speech therapy, occupational therapy, physical therapy, and Applied Behavior Analysis services for an individual under 18 years of age or an individual 18 years of age or older who is in high school who has been diagnosed as having a developmental disability at 8 years of age or younger.

8.08.01 Coverage shall be limited to services that are prescribed by the treating Physician in accordance with a treatment plan. The treatment plan required shall include, but is not limited to, a diagnosis, the proposed treatment by type, the frequency and duration of treatment, the anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the treating Physician.

8.09 **Diagnostic imaging and laboratory**. All prescribed diagnostic imaging and laboratory tests and services including diagnostic imaging, fluoroscopy, electrocardiograms, blood and urine and other laboratory tests, and diagnostic clinical isotope services are covered when Medically Necessary and ordered by a Physician as part of the diagnosis and/or treatment of a covered illness or injury or as preventive health care services.

8.10 **Diagnostic testing and treatment related to Attention Deficit Hyperactivity Disorder (ADHD)**. Coverage is subject to applicable Copayments, Coinsurance and coverage limitations as outlined on the Schedule of Benefits. Covered services do not include those that are primarily educational or training in nature.

8.11 **Durable Medical Equipment (DME)**. This Plan provides benefits, when Medically Necessary, for the purchase or rental of such DME that:

8.11.01 can withstand repeated use (i.e. could normally be rented and used by successive patients);

8.11.02 is primarily and customarily used to serve a medical purpose;

8.11.03 generally is not useful to a person in the absence of illness or injury; and

8.11.04 is appropriate for use in a patient's home.

8.11.05 Some examples of DME are: hospital beds, crutches, canes, walkers, wheelchairs, oxygen, respiratory equipment, apnea monitors and insulin pumps. It does not include hearing aids or corrective lenses, or the professional fee for fitting same. It also does not include medical supplies and devices, such as a corset, which do not require prescriptions. The Plan will pay for rental of equipment up to the purchase price. Repair and/or replacements are not covered if equipment has been lost, stolen, abused or misused.

8.11.06 Oxygen is covered when Medically Necessary pursuant to AvMed's coverage guidelines, which are available free of charge upon request. The type of oxygen delivery system covered (stationary, portable, ambulatory) is based on the Participant's activity status. Initial coverage is contingent upon arterial blood gas results. Reassessment of oxygen needs through pulse oximetry at rest and after exercise is required and must be performed by an independent respiratory provider at three months after the initiation of therapy and then yearly in order to re-qualify coverage of oxygen therapy.

8.11.07 The determination of whether a covered item will be paid under the DME, orthotics or prosthetics benefits will be based upon its classification as defined by the Centers for Medicare and Medicaid Services.

8.12 **Emergency services**. The Plan will cover all necessary Physician and Hospital Services for Emergency Medical Services and Care. See Sections 2.22 and 2.23. In the event Hospital inpatient services are provided following Emergency Medical Services and Care, AvMed should be notified by the Hospital, Participant or designee, within 24-hours of the inpatient admission if reasonably possible. AvMed may elect to transfer the Participant to a Participating Provider as soon as it is medically appropriate to do so. If the Participant chooses to stay in the Non-participating facility after the date AvMed decides a transfer is medically appropriate, Out-of-Network benefits may be available if the continued stay is determined to be a covered health service. In addition, any Participant requests for reimbursement (of payment made by the Participant for services rendered) must be filed within 90 days after the emergency, or as soon as reasonably possible, but not later than one year unless the Claimant was legally incapacitated.

8.13 **General anesthesia and hospitalization services to a Participant who is under 8 years of age** and is determined by a licensed dentist and the Participant's Physician to require necessary dental treatment in a Hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or if the Participant has one or more medical conditions that would create significant or undue medical risk for the Participant in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or ambulatory surgical center. Pre-authorization by AvMed is required. There is no coverage for diagnosis or treatment of dental disease.

8.14 **Home Health Care Services (Skilled Home Health Care)**. Home Health Care Services (as defined in Section 2.32) are covered when ordered by and under the direction of the Participant's Attending Physician. Services are limited to a period of two hours or less per visit, and 60 visits per Calendar Year. Rehabilitative physical, occupational or speech therapy services provided in the home are limited as noted in Section 9.09. Home Health Care Services that do not include a medical, diagnostic, therapeutic or rehabilitative component or that do not require the skill of a registered nurse, licensed practical (vocational) nurse or other healthcare personnel are not covered. Homemaker or other Custodial Care services are not covered.

8.15 **Hospital care: inpatient**. All non-emergency Hospital inpatient services received at a Hospital for non-mental illness or injury are provided when prescribed by a Physician and pre-authorized by AvMed. Inpatient services include semi-private room and board, birthing rooms, newborn nursery care, nursing care, meals and special diets when Medically Necessary, use of operating rooms and related facilities, the intensive care unit and services, diagnostic imaging, laboratory and other diagnostic tests, medications, biologicals, anesthesia and oxygen supplies, physical therapy, radiation therapy, respiratory therapy, and administration of blood or blood plasma. See Section 8.12 with regard to inpatient admission following Emergency Medical Services and Care.

8.16 **Hospice services**. Services are available from a Hospice organization for a Participant whose attending Physician has determined the Participant's illness will result in a remaining life span of 18 months or less.

8.17 **Major organ transplants** at a facility deemed appropriate and authorized by AvMed, as well as associated immunosuppressant medications are covered except those deemed Experimental. See Section 10.15. Organ acquisition and donor costs are covered, including complications and pre-transplant services.

8.18 **Mammograms** are covered in accordance with Florida Statutes and the U.S. Preventive Services Task Force (USPSTF) preventive services recommendations (Grade A and B). One baseline mammogram is covered for female Participants between the ages of 35 and 39. A mammogram is available every two years for female Participants between the ages of 40 and 49 and a mammogram is available every year for female Participants aged 50 and older.

8.18.01 In addition, one or more mammograms a year are available when based upon a Physician's recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has had breast cancer, or because a woman has not given birth before the age of 30.

8.19 **Mastectomy surgery**. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Right's Act of 1988 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the Attending Physician and the patient, for:

8.19.01 all stages of reconstruction of the breast on which the mastectomy has been performed;

8.19.02 surgery and reconstruction on the other breast to produce a symmetrical appearance; and

8.19.03 prostheses and physical complications during all stages of mastectomy including lymphedemas.

8.19.04 The length of stay will not be less than that determined by the Attending Physician to be Medically Necessary in accordance with prevailing medical standards and after consultation with the covered patient. The Attending Physician, after consultation with the covered patient, may choose that the outpatient care be provided at the most medically appropriate setting, which may include the Hospital, treating Physician's office, outpatient center or home of the covered patient.

8.19.05 Coverage is subject to the same Copayments or Coinsurance applicable to other medical and surgical benefits provided under the Plan, and will require prior authorization of services as applicable to other surgical procedures or hospitalizations under the Plan.

8.19.06 If you would like more information on WHCRA benefits, call AvMed at 1-844-263-2369.

8.20 **Mental Health Services.** Inpatient intermediate and outpatient Mental Health Services are covered when Medically Necessary and may be covered when a Participant is admitted to a Hospital or Other Health Care Facility.

8.20.01 Intermediate Mental Health Services in a Residential Treatment facility may be covered under a 24-hour intensive and structured supervised treatment program providing an inpatient level of care but in a non-Hospital environment, for those disorders that cannot be effectively treated in an outpatient or Partial Hospitalization environment. Prior Authorization is required.

8.20.02 Partial Hospitalization may be covered under a structured program of active psychiatric treatment provided in a Hospital outpatient setting or by a community mental health center, that is more intense than the care received in a Physician's or therapist's office, as an alternative to inpatient hospitalization. Prior Authorization is required.

8.20.03 Outpatient, and intensive outpatient treatment for mental health disorders may be covered when provided by a state-licensed psychiatrist or other Physician, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, Physician assistant, or other qualified mental health professional as allowed under applicable state law.

8.21 **Nutrition Therapy**. Enteral formulas, nutritional supplements and low protein modified foods for use at home by a covered person that are prescribed or ordered by a health care practitioner and are for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU). Coverage shall include food products modified to be low protein for a covered person.

8.22 **Newborn care**. All services applicable for children under the Plan are covered for an enrolled newborn child of the Covered Employee, or the enrolled newborn child of a Covered Dependent of the Covered Employee, or the newborn adopted child of the Covered Employee (as described in Section 3.02.04), from the moment of birth, including the Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, and transportation costs to the nearest facility appropriately staffed and equipped to treat the newborn's condition when such transportation is Medically Necessary. Circumcisions are provided for up to one year from date of birth.

8.23 **Obstetrical and gynecological care**. An annual gynecological examination and Medically Necessary follow-up care detected at that visit are available without the need for a prior referral. Participants do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of health care professionals

who specialize in obstetrics or gynecology, please refer to your provider directory. Obstetrical care benefits as specified herein are covered and include Hospital care, anesthesia, diagnostic imaging and laboratory services for conditions related to pregnancy unless such pregnancy is the result of a preplanned adoption arrangement, more commonly known as surrogacy. The length of maternity stay in a Hospital will be that determined to be Medically Necessary in compliance with Florida law and in accordance with the Newborns' and Mothers' Health Protection Act (NMHPA). Group health plans and health insurance issuers generally may not, under Federal law (including the NMHPA), restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child below certain levels. These levels are as follows:

8.23.01 Hospital stays of at least 48 hours following a normal vaginal delivery, or at least 96 hours following a cesarean section (under Federal law, the Plan may not require that your provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 or 96 hours, as appropriate);

8.23.02 The Attending Physician does not need to obtain authorization from AvMed to prescribe a Hospital stay of this length;

8.23.03 The Plan will cover an extended stay, if Medically Necessary; however, the Physician or Hospital must pre-certify the extended stay.

8.23.04 Shorter Hospital stays are permitted if the Attending Physician, in consultation with the mother, determines that to be best course of action. Coverage for maternity care is subject to applicable Copayments and all other Plan limits and requirements.

8.24 **Orthotic appliances**. Coverage for orthotic appliances is limited to custom-made leg, arm, back and neck braces when related to a surgical procedure or when used in an attempt to avoid surgery and when necessary to carry out normal activities of daily living, excluding sports activities. Coverage includes the initial purchase, fitting or adjustment. Replacements are covered only when Medically Necessary due to a change in bodily configuration. All other orthotic appliances are not covered. The determination of whether a covered item will be paid under the DME, orthotics or prosthetics benefits will be based upon its classification as defined by the Centers for Medicare and Medicaid Services.

8.25 **Osteoporosis diagnosis and treatment** when Medically Necessary for high-risk individuals, including but not limited to, estrogen-deficient individuals, individuals with vertebral abnormalities, individuals on long-term glucocorticoid (steroid) therapy, individuals with primary hyperparathyroidism and individuals with a family history of osteoporosis.

8.26 **Other Health Care Facility(ies)**. All routine services of Other Health Care Facilities (see Section 2.45), including Physician visits, physiotherapy, diagnostic imaging and laboratory work, are covered when a Participant is admitted to such a facility, following discharge from a Hospital, for a condition that cannot be adequately treated with Skilled Home Health Care Services or on an ambulatory basis.

8.27 **Outpatient therapeutic services**. Covered health services for therapeutic treatments received on an outpatient basis in the home, Physician's office, Other Health Care Facility or Hospital, including intravenous chemotherapy or other intravenous infusion therapy and Injectable Medications. Self-Administered Injectable Medications are only a covered benefit when included in the supplemental prescription medication benefits.

8.28 **Physical, occupational or speech therapy**. Short-term rehabilitative physical, occupational and speech therapy provided in an outpatient or home care setting is covered to improve or restore physical functioning following disease, injury or loss of a body part. Habilitative physical, occupational and speech therapy provided in an outpatient or home care setting is covered when provided to help a person keep, learn or improve skills and functioning for daily living. Spinal manipulations/adjustments will be covered when performed in a health care practitioner's office, or in rehabilitation facility on an inpatient or outpatient basis. Clinical documentation or a treatment plan to support the need for therapy services

or continuing therapy must be submitted for review. Please refer to your Schedule of Benefits for applicable benefit maximums and Limitations.

8.28.01 Continued therapy is only Medically Necessary when this care is prescribed by a Physician in order to significantly improve, develop or restore physical functions that have been lost or impaired. Using additional diagnoses to obtain additional therapy for the same condition is not considered Medically Necessary. Once maximum therapeutic benefit has been achieved, and there is no longer any progression, or a home exercise program could be used for any further gains, continuing supervised therapy is not considered Medically Necessary. Therapy in persons whose condition is neither regressing nor improving is considered not Medically Necessary. Therapy in asymptomatic persons or in persons without an identifiable clinical condition is considered not Medically Necessary.

8.28.02 Additional therapy can be considered for a new or separate condition in a person who previously received therapy for another indication. An exacerbation or flare-up of a chronic illness is not considered a new incident of illness.

8.28.03 Home-Based Physical Therapy is Medically Necessary in selected cases based upon the Member's needs i.e., the Member must be homebound. This may be considered Medically Necessary in the transition of the Member from Hospital to home, and may be an extension of case management services.

8.28.04 Non-covered services include:

a. Services that involve non-diagnostic, non-therapeutic, routine, or repetitive procedures to maintain general welfare and do not require the skilled assistance of a licensed therapist.

b. Services such as general exercise programs to promote overall fitness and endurance, for diversion or for general motivation.

c. Other non-covered treatments specifically for Autism and Autism Spectrum disorders unless required by federal or Florida law.

d. Physical therapy modalities that are considered investigational and not covered include, but are not limited to: Interactive Metronome Program, Augmented Soft Tissue Mobilization, Kinesio Taping/Taping, MEDEK Therapy, Hands-Free Ultrasound and Low-Frequency Sound (Infrasound), and Hivamat Therapy (Deep Oscillation Therapy).

8.29 **Physician care: inpatient**. All Medical Services rendered by Physicians and other Health Professionals when requested or directed by the Attending Physician, including surgical procedures, anesthesia, consultation and treatment by Specialty Health Care Physicians, laboratory and diagnostic imaging services, and physical therapy (see Section 8.28) are covered while the Participant is admitted to a Hospital as a registered bed patient. When available and requested by the Participant, the Plan covers the services of a certified nurse anesthetist licensed under Chapter 464, *Florida Statutes*.

8.30 **Physician care: outpatient**

8.30.01 **Diagnosis and treatment**. All Medical Services rendered by Physicians and other Health Professionals, are covered when Medically Necessary and when provided at Medical Offices, including surgical procedures, routine hearing examinations and vision examinations for glasses for children under age 18 (such examinations may be provided by optometrists licensed pursuant to Chapter 463, *Florida Statutes* or by ophthalmologists licensed pursuant to Chapter 458 or 459, *Florida Statutes*), or if applicable, equivalent or similar laws of another state, and consultation and treatment by Specialty Health Care Physicians. Also included are non-reusable materials and surgical supplies. These services

and materials are subject to the Limitations outlined in Section IX (LIMITATIONS OF BASIC BENEFITS). See Section X (EXCLUSIONS FROM BASIC BENEFITS).

8.30.02 **Preventive and health maintenance services**. Coverage includes services of Physicians for illness prevention and health maintenance, including items or services that have an A or B rating in current recommendations of the U.S. Preventive Services Task Force (USPSTF); immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-informed preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional preventive care and screening (with respect to women) provided for in guidelines supported by the Health Resources and Services Administration.

8.31 **Prescription medication benefits**. Allergy serums and chemotherapy for cancer patients are covered. Coverage for insulin and other diabetic supplies is described in Section 8.07. Other retail prescription medications are a covered benefit when the Plan includes prescription medication benefits; coverage is subject to the Copayment/Coinsurance provisions outlined therein. See the form entitled Prescription Medication Benefits for a description of other prescription medication coverage.

8.32 **Prosthetic devices**. This Plan provides benefits, when Medically Necessary, for prosthetic devices designed to restore bodily function or replace a physical portion of the body. Coverage for prosthetic devices is limited to artificial limbs, artificial joints, ocular prostheses and cochlear implants. Coverage includes the initial purchase, fitting or adjustment. Replacement is covered only when Medically Necessary due to a change in bodily configuration. The initial prosthetic device following a covered mastectomy is also covered. Replacement of intraocular lenses is covered only if there is a change in prescription that cannot be accommodated by eyeglasses. All other prosthetic devices are not covered, including prosthetic devices for Deluxe, Myo-electric and electronic prosthetic devices. The determination of whether a covered item will be paid under the DME, orthotics or prosthetics benefits will be based upon its classification as defined by the Centers for Medicare and Medicaid Services.

8.33 **Removal of benign skin lesions** including, but not limited to, warts, moles, skin tags, lipomas, keloids and scars are covered.

8.34 **Second medical opinions**. The Participant is entitled to a second medical opinion when he disputes the appropriateness or necessity of a surgical procedure or is subject to a serious injury or illness.

8.34.01 The Participant may obtain a second medical opinion from any participating or non-participating Physician, chosen by the Participant. If a Participating Physician is chosen, there is no cost to the Participant other than any applicable Copayment or Coinsurance. If the Participant chooses an Out-of-Network Provider, the Participant will be responsible for the applicable Deductible or 40% of the amount of the Maximum Allowable Payment associated with the consultation.

8.34.02 Once a second medical opinion has been rendered, AvMed shall review and determine the treatment obligations of the Plan, and that judgment is controlling, subject to the Plan's appeals process. Any treatment the Participant obtains that is not authorized by AvMed shall be at the Participant's expense.

8.34.03 The Plan may limit second medical opinions in connection with a particular diagnosis or treatment to three per Calendar Year, if additional opinions are deemed to be an unreasonable over-utilization by the Participant.

8.35 **Spinal manipulations** will be covered only when Medically Necessary.

8.36 **Substance Abuse Services.** Inpatient intermediate and outpatient Substance Abuse Services are covered when Medically Necessary and may be covered when a Participant is admitted to a Hospital or Other Health Care Facility.

8.36.01 Intermediate Substance Abuse Services in a Residential Treatment facility may be covered under a 24-hour intensive and structured supervised treatment program providing an inpatient level of care but in a non-Hospital environment, for those disorders that cannot be effectively treated in an outpatient or Partial Hospitalization environment. Prior Authorization is required.

8.36.02 Partial Hospitalization may be covered under a structured program of active psychiatric treatment provided in a Hospital outpatient setting or by a community mental health center, that is more intense than the care received in a Physician's or therapist's office, as an alternative to inpatient hospitalization. Prior Authorization is required.

8.36.03 Outpatient, and intensive outpatient treatment for substance use disorders may be covered when provided by a state-licensed psychiatrist or other Physician, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other qualified mental health professional as allowed under applicable state law.

8.37 **Supplies**. Ostomy, urostomy, wound care supplies and flotation pads are covered when Medically Necessary. Wound care supplies are covered as part of an approved treatment plan, when the wound is caused by or treated by a surgical procedure, or requires debridement. Provision of ostomy, urostomy and wound care supplies is limited to a one-month supply every 30 days. Items which are not medical supplies or which could be used by the Participant or a family member for purposes other than ostomy care are not covered.

8.38 **Temporomandibular Joint Dysfunction (TMJ)**. The Plan will pay benefits for covered services during a plan of treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and the skull, subject to the maximum benefit shown on the Schedule of Benefits, if any. Expenses covered under this jaw joint benefit are not covered under any other provision of this plan.

8.38.01 The following are covered expenses:

a. A single examination including a history, physical examination, muscles testing, range of motion measurements, and psychological evaluation;

b. Diagnostic x-rays;

c. Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;

d. Therapeutic injections;

e. Appliance therapy utilizing an appliance which does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the maximum allowable fee for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance;

f. Limited to one splint in a six-month period; and

g. Surgical procedures.

8.39 **Transplant services,** limited to the procedures listed below, are covered when performed at an AvMed contracted transplant facility, subject to the conditions and Limitations described in Section IX

(LIMITATIONS OF BASIC BENEFITS). Transplant services are subject to Prior Authorization. Transplant includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation.

8.39.01 Covered expense for an organ transplant includes pre-transplant services, transplant inclusive of any chemotherapy and associated services, post-discharge services, and treatment of complications after transplantation of the following organs or procedures only:

a. Heart;

b. Lung(s);

c. Liver;

d. Kidney;

e. Bone marrow;

f. Intestine;

g. Pancreas;

h. Auto islet cell;

i. Any combination of the above listed organs; and

j. Any organ not listed above required by state or federal law.

8.39.02 The following are covered expenses for approved organ transplants and all related complications:

a. Hospital and health care practitioner services.

b. Organ acquisition and donor costs, including pre-transplant services, the acquisition procedure, and any complications resulting from the acquisition.

c. Direct, non-medical costs for:

i. The Participant receiving the organ transplant, if he or she lives more than 50 miles from the transplant facility; and

ii. One designated caregiver or support person (two, of the Participant receiving the organ transplant is under 18 years of age), if they live more than 50 miles from the transplant facility.

d. Direct, non-medical cost include:

i. Transportation to and from the Hospital where the organ transplant is performed; and

ii. Temporary lodging at a prearranged location when requested by the Hospital and approved by AvMed.

8.39.03 All direct, non-medical costs for the Participant receiving the organ transplant and the designated caregiver(s) or support person(s) are limited to a combination maximum coverage per organ transplant, as specified in the "Schedule of Benefits – Transplant Services" section.

8.40 **Urgent care services**. All necessary and covered services received in an Urgent Care Center, retail clinic or a Primary Care Physician's office after-hours for conditions as described in Section 2.68 will be covered by AvMed. In addition, any Participant requests for reimbursement (of payment made by the Participant for services rendered) must be filed within 90 days after the emergency or as soon as reasonably possible but not later than one year unless the Participant was legally incapacitated.

8.41 **Ventilator Dependent care**. With prior authorization by AvMed, ventilator dependent care is covered. (see Section 2.71).

IX. LIMITATIONS OF BASIC BENEFITS

The rights of Participants hereunder are subject to the following Limitations:

9.01 **Cardiac rehabilitation**. Coverage of cardiac rehabilitation is limited to a maximum of 18 visits per Calendar Year.

9.02 **Chiropractic/Spinal Manipulation** is limited to 60 visits per calendar year.

9.03 **Habilitative physical, occupational & speech therapies.** When provided for the treatment of Autism Spectrum Disorder, services are limited to a combined maximum of 100 visits per calendar year.

9.04 **Home Health Care Services (Skilled Home Health Care)** visits are limited to a period of two hours or less per visit and 60 visits per Calendar Year.

9.05 **Licensed dietitians/nutritionists**. Visits to licensed dietitians/nutritionists for treatment of obesity control shall be limited to four outpatient visits per Calendar Year and each visit requires a Copayment. See Section 10.18.

9.06 **Mental health and substance abuse services.** Intermediate inpatient/Residential Treatment is limited to 100 days per Calendar Year.

9.07 **Orthotic appliances**. Coverage for orthotic appliances is limited to custom-made leg, arm, back and neck braces when related to a surgical procedure or when used in an attempt to avoid surgery and when necessary to carry out normal activities of daily living, excluding sports activities.

9.08 **Prosthetic devices**. Coverage for prosthetic devices is limited to artificial limbs, artificial joints, ocular prostheses and cochlear implants.

9.09 **Rehabilitative physical, occupational or speech therapy**. Coverage of outpatient physical, occupational and speech therapy is limited to a combined total of 60 visits per Calendar Year including evaluations.

9.10 **Second medical opinions**. AvMed may limit second medical opinions in connection with a particular diagnosis or treatment to three per Calendar Year, if AvMed deems additional opinions to be an unreasonable over-utilization by the Participant.

9.11 **Skilled nursing facilities and rehabilitation centers**. Routine services are covered up to a combined maximum of 100 post-hospitalization days per calendar year. Services for the treatment of mental health or substance use disorders are limited to a combined maximum of 100 days per calendar year.

9.12 **Transportation for Major Organ Transplant services**. Transportation for transplant services is administered through Optum Health, an AvMed third party partner. Charges are limited to $200 per day up to $10,000 lifetime maximum per covered organ transplant for a companion to accompany the Participant (or 2 companions when the patient is a minor) and the Participant has to travel greater than a 50 mile radius to receive the transplant. This service is available only when the transplant is authorized at one of AvMed's contracted transplant facilities.

X. EXCLUSIONS FROM BASIC BENEFITS

Medical Services and benefits for the following classifications and conditions are not covered and are excluded from the Schedule of Basic Benefits provided under this Plan:

10.01 **Aids or devices that assist with nonverbal communications**, including but not limited to communication boards, communication devices (except after surgical removal of the larynx or a

diagnosis of permanent lack of function of the larynx), prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.

10.02 **Armed forces service-connected medical care** for both sickness and injury.

10.03 **Autopsy or postmortem examinations** and associated services.

10.04 **Breast reduction or augmentation**. Surgery for the reduction or augmentation of the size of the breasts unless medically necessary, except as required for the comprehensive treatment of breast cancer.

10.05 **Complementary or alternative medicine** including but not limited to, acupuncture; aromatherapy, Ayurvedic medicine such as lifestyle modifications, purification and massage therapies; behavioral training, biofield therapies; bioelectromagnetic applications and medicine; biofeedback; chelation therapy; cognitive therapy; environmental medicine including the field of clinical ecology; herbal therapies; homeopathic medicine and counseling; hypnotherapy; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; manual healing methods such as the Alexander technique, massage therapy including but not limited to: craniosacral balancing, Feldenkrais method, Hellerwork, reflexology, Rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and polarity therapy; naturopathic medicine; prayer and mental healing; Reichian therapy, Reiki, self-care and self-help training; sex therapy, SHEN therapy, sleep therapy, therapeutic touch; thermography; traditional Chinese medicine including acupuncture and vocational rehabilitation.

10.06 **Complications of any non-covered service**, including the evaluation or treatment of any condition that arises as a complication of a non-covered service.

10.07 **Cosmetic, surgical or non-surgical procedures** which are undertaken primarily to improve or otherwise modify the Participant's external appearance are excluded, except for reconstructive surgery to correct and repair a functional disorder as a result of a disease, injury, or congenital defect or initial implanted prosthesis and reconstructive surgery incident to a mastectomy for cancer of the breast. Also excluded are surgical excision or reformation of any sagging skin of any part of the body, including, but not limited to: the eyelids, face, neck, abdomen, arms, legs or buttocks; any services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body, including, but not limited to: the face, lips, jaw, chin, nose, ears, breasts or genitals (including circumcision, except newborns for up to one year from date of birth (see Section 8.19); hair transplantation, chemical face peels or abrasion of the skin, electrolysis depilation, removal of tattooing; or any other surgical or non-surgical procedures which are primarily for cosmetic purposes or to create body symmetry. Additionally, all medical complications as a result of cosmetic, surgical or non-surgical procedures are excluded.

10.08 **Cosmetics, dietary supplements, health or beauty aids**.

10.09 **Custodial Care** as defined in Section 2.19.

10.10 **Dental Care**, as defined in Section 2.21, for any condition except:

10.10.01 services, supplies or appliances for Dental Care necessary to promptly repair (but not replace), sound natural teeth required as a result of and directly related to an accidental injury sustained while covered under the Plan. Treatment must begin 90 days from date of injury and must be completed within nine months from date of injury.

10.10.02 reconstructive jaw surgery for the treatment of deformities that are present and apparent at birth; or

10.10.03 services for the treatment of tumors or full mouth extraction when required before radiation therapy.

10.11 **Diagnostic testing and treatment** related to mental retardation or deficiency, learning disabilities, behavioral problems and developmental delays. Expenses for remedial or special education, counseling, or therapy including evaluation and treatment of the above-listed conditions or behavioral training whether or not associated with manifest mental disorders or other disturbances.

10.12 **Durable Medical Equipment (DME)** items that are not covered include, but are not limited to the following:

10.12.01 bed related items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses;

10.12.02 bath related items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas;

10.12.03 chairs, lifts and standing devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is 2-person transfer), and auto tilt chairs;

10.12.04 electric or powered scooters; non-standard customized wheelchairs, motorized or manual;

10.12.05 fixtures to real property: ceiling lifts and wheelchair ramps;

10.12.06 car/van modifications;

10.12.07 air quality items: air conditioners, room humidifiers, vaporizers, air purifiers and electrostatic machines;

10.12.08 blood/injection related items: blood pressure cuffs, centrifuges, nova pens and needleless injectors; and

10.12.09 other equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment, emergency alert equipment and diathermy machines.

10.12.10 The replacement of Durable Medical Equipment solely because it is old or used is excluded.

10.13 **Emergency room services for non-emergency purposes**. See Sections 2.22 and 2.23.

10.14 **Exercise programs,** gym memberships, or exercise equipment of any kind, including, but not limited to: exercise bicycles, treadmills, stair-masters, rowing machines, free weights or resistance equipment. Also excluded are massage devices, portable whirlpool pumps, hot tubs, Jacuzzis, sauna baths, swimming pools and similar equipment.

10.15 **Experimental and/or Investigational procedures**, except for bone marrow transplants, as approved per Section 59B-12.001, Florida Administrative Code, and clinical trials as set forth in Section 8.03.06.

10.16 **Eye care including**:

10.16.01 eye examinations for Participants 18 years of age or older for the purpose of determining the need for sight correction (such as eye glasses or contact lenses);

10.16.02 training or orthoptics, including eye exercises; or

10.16.03 radial keratotomy, refractory keratoplasty, Lasik surgery or any other corneal surgical procedure to correct refractive error.

10.17 **Foot supports** are not covered, except for arch supports (foot orthotics) and orthopedic shoes for diabetes and hammertoe. 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.

10.18 **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.

10.19 **Gender reassignment** surgery as well as any service, supply, or medical care associated with gender reassignment or gender identity disorders.

10.20 **Home monitoring devices and measuring devices** (other than apnea monitors), and any other equipment or devices for use outside the Hospital.

10.21 **Hospital Services that are associated with excluded surgery or excluded Dental Care**.

10.22 **Hearing examinations for Participants 18 years of age or older** for the purpose of determining the need for hearing correction.

10.23 **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.

10.24 **Immunizations and medications** for the purpose of foreign travel or employment.

10.25 **Mandibular and maxillary osteotomies** except when Medically Necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.

10.26 **Medical care or surgery** not within the benefits covered by this Plan.

10.27 **Medical supplies** including, but not limited to: pre-fabricated splints, Thromboemboletic/Support hose and all other bandages, except as provided in Sections 8.11 and 8.37.

10.28 **Mental Health Services** shall not be covered if treatment is:

10.28.01 rendered in connection with a condition not classified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association; or

10.28.02 extended beyond the period necessary for diagnosis of learning and behavioral disabilities or for mental retardation; or

10.28.03 for marriage counseling; or

10.28.04 court ordered care or testing or required as a condition of probation or parole; or

10.28.05 testing for aptitude, ability, intelligence, or interest.

10.29 **Nutrition Therapy**. Vitamins, dietary supplements, and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU).

10.30 **Over-the-counter medications** and prescription medications not otherwise covered including all contraceptives (medications and devices), hypodermic needles and syringes and Injectable Medications except insulin and insulin syringes for the treatment of diabetes as outlined in Sections 8.06 and 8.07.

10.31 **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 8.01), air conditioners, humidifiers, dehumidifiers, and air purifiers or filters.

10.32 **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.

10.33 **Physical, occupational, speech and all other therapies for chronic conditions**. Maintenance therapy is not covered. Maintenance therapy begins when the therapeutic goals of a treatment plan have been met and/or no further functional progress is expected. Speech therapy for non-organic or functional disorders is not covered, except for the initial evaluation to determine the root cause. Examples include attention deficit disorder, developmental delay, mental retardation, and Down's syndrome. Abnormal speech pathology, including but not limited to lisping and stuttering, is not covered.

10.34 **Private duty nursing services**.

10.35 **Rehabilitation programs**. Vocational rehabilitation, pulmonary rehabilitation or long term rehabilitation programs.

10.36 **Reversal of sterilization procedures**.

10.37 **Sexual dysfunction**. All medications, devices, and other forms of treatment related to a diagnosis of sexual dysfunction.

10.38 **Surgically implanted devices** and any associated external devices, except for cardiac pacemakers, intraocular lenses, cochlear implants, artificial joints, orthopedic hardware, vascular grafts, and ventricular assist devices, if indicated, when used as a bridge to heart transplantation. Dental appliances, other corrective lenses and hearing aids, including the professional fee for fitting them, are not covered.

10.39 **Temporomandibular Joint Dysfunction (TMJ).** Covered expenses do not include:

10.39.01 Computed Tomography (CT) scans or magnetic resonance imaging except in conjunction with surgical management;

10.39.02 Electronic diagnostic modalities;

10.39.03 Occlusal analysis; or

10.39.04 Any irreversible procedure, including, but not limited to: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures, full dentures.

10.40 **Termination of pregnancy** unless deemed Medically Necessary by the Medical Director, subject to applicable State and Federal laws. Coverage is available if the pregnancy would endanger the life of the mother, if the pregnancy is a result of rape or incest, or the fetus has been diagnosed with a lethal or otherwise significant abnormality.

10.41 **Transplant services,** no benefit is payable for or in connection with an organ transplant if:

10.41.01 It is experimental or investigational, or for research purposes unless the particular use of the bone marrow transplant procedure is determined to be accepted within in the appropriate oncological specialty and not experimental pursuant to 627.4236 (3).

10.41.02 The expense relates to storage of cord blood and stem cells, unless it is an integral part of an organ transplant approved by AvMed.

10.41.03 AvMed does not approve coverage for the organ transplant, based on our established criteria.

10.41.04 Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.

10.41.05 The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the master group contract.

10.41.06 The expense related to the donation or acquisition of an organ for a recipient who is not covered by the Plan.

10.41.07 The expense relates to an organ transplant performed outside of the United States and any care resulting from that organ transplant.

10.41.08 A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow-up care, immunosuppressive drugs, and expenses related to complications of such transplant.

10.41.09 You have not met pre-transplant criteria as established by AvMed.

10.42 **Travel expenses** including expenses for ambulance services to and from a Physician or Hospital except in accordance with Section 8.01. Ambulance services are not covered when the skill of medically trained personnel is not required and the Participant can be safely transported by other means.

10.43 **Treatment of a condition resulting from**:

10.43.01 participation in a riot or rebellion;

10.43.02 engagement in an illegal occupation;

10.43.03 participation in, or commission of, any act punishable by law as a felony whether or not the individual is charged or convicted.

10.44 **Workers' Compensation benefits**. Any sickness or injury for which the Participant is paid benefits, or may be paid benefits if claimed, if the Participant is covered or required to be covered by Workers' Compensation. In addition, if the Participant enters into a settlement giving up rights to recover past or future medical benefits under a Workers' Compensation law, the Plan shall not cover past or future Medical Services that are the subject of or related to that settlement. Furthermore, if the Participant is covered by a Worker's Compensation program that limits benefits if other than specified health care providers are used and the Participant receives care or services from a health care provider not specified by the program, the Plan shall not cover the balance of any costs remaining after the program has paid.

XI. COORDINATION OF BENEFITS

11.01 The services and benefits provided under this Plan are not intended to and do not duplicate any benefit to which Participants are entitled under any other Group Health Insurance, HMO, personal injury protection and medical payments under the automobile insurance laws of this or any other jurisdiction, governmental organization, agency, or any other entity providing health or accident benefits to a Participant, including but not limited to: Medicare, Worker's Compensation, Public Health Service, CHAMPUS, Maritime Health Benefits, or similar state programs as permitted by contract, policy, or law. Plan coverage will be primary to Medicaid and Children's Health Insurance Program (CHIP) benefits.

11.02 If any Participant is eligible for services or benefits under two or more plans as set forth in Section 11.01, 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 Participant shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Plan. Failure to do so will result in nonpayment of Claims. Requested information

should be provided to AvMed within 30 days of request or Participant will be responsible for payment of the Claim. Information received after one year from date of service will not be considered.

11.03 The standards governing the coordination of benefits are the following, in accordance with the provisions of Chapter 627.4235, *Florida Statutes*:

11.03.01 The benefits of a policy or plan that covers the person as a Covered Employee or Participant, other than as a Dependent, are determined before those of the policy or plan which covers the person as a Dependent.

11.03.02 Except as stated in Section 11.03.03, when two or more policies or plans cover the same child as a Dependent of different parents:

a. The benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls earlier in a year are determined before 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.

11.03.03 If two or more policies or plans cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

a. First, the policy or plan of the parent with custody of the child;

b. Second, the policy or plan of the spouse of the parent with custody of the child; and

c. Third, the policy or plan of the parent not having custody of the child.

d. However, if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the child and if the entity obliged to pay or provide the benefits of the policy or plan of that parent has actual knowledge of those terms, the benefits of that policy or plan are determined first. This does not apply with respect to any claim determination period or plan or policy year during which any benefits are actually paid or provided before that entity has that actual knowledge.

11.03.04 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 Section shall not apply.

11.03.05 If none of the rules in Sections 11.03.01 through 11.03.04 determine the order of benefits, the benefits of the policy or plan which covered an employee, Participant 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.

11.03.06 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, Participant, or subscriber.

b. Second, benefits of a plan of an active worker covering a person as a Dependent.

c. Third, Medicare benefits.

11.03.07 Medicare shall be considered the secondary plan and this Plan shall be considered the primary plan with respect to the following Participants entitled to Medicare:

a. For Medicare entitlement due to age, active employees and their spouses;

b. For Medicare entitlement due to disability, employees under this Plan due to current employment status and their family Members;

c. For Medicare entitlement due to end-stage renal disease, all Participants during the first 30 months of Medicare entitlements.

d. For all other covered persons entitled to Medicare, this Plan shall be secondary plan. When this Plan is secondary to Medicare, the amount payable under this Plan shall be reduced by the amount payable under Medicare, if any, regardless of whether the covered person has enrolled in Medicare.

11.03.08 If an individual is covered under COBRA continuation coverage and also under another group plan, the following order of benefits applies:

a. First, the plan covering the person as an employee or as the employee's Dependent.

b. Second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's Dependent provided according to the provisions of COBRA.

11.04 For the purpose of determining the applicability and implementing the terms of the Coordination of Benefits provision of the Plan, AvMed may, without the consent of or notice to any person, release to or obtain from any other insurance company, organizations or person, any information, with respect to any Participant, or applicant for participation, which AvMed deems to be necessary for such purposes.

11.05 Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts the Plan shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan.

11.06 All treatments must be Medically Necessary and comply with all terms, conditions, Limitations, and Exclusions of this Plan even if this Plan is secondary to other coverage and the treatment is covered under the other coverage.

11.07 If the amount of the payments made by the Plan is more than it should have paid under the provisions of this Section XI, 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 Participant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

11.08 In the event the Employer 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.

XII. SUBROGATION AND RIGHT OF RECOVERY

12.01 If the Plan provides health care benefits to a Participant for injuries or illness for which another party is or may be responsible, then the Plan retains the right to repayment of the full cost of all benefits provided by the Plan on behalf of the Participant that are associated with the injury or illness for which another party is or may be responsible. The Plan's rights of recovery apply to any recoveries made by or on behalf of the Participant from the following third-party sources, as allowed by law, including but not limited to: payments made by a third-party tortfeasor or any insurance company on behalf of the third-party tortfeasor; any payments or awards under an uninsured or underinsured motorist coverage policy; any worker's compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; any other payments from a source intended to compensate a Participant for injuries resulting from an accident or alleged negligence. For purposes of this SPD, a tortfeasor is any party who has committed injury, or wrongful act done willingly, negligently or in circumstances involving strict liability, but not including breach of contract for which a civil suit can be brought.

12.02 Participant specifically acknowledges the Plan's right of subrogation. When the Plan provides health care benefits for injuries or illnesses for which a third party is or may be responsible, the Plan shall be subrogated to the Participant's rights of recovery against any party to the extent of the full cost of all benefits provided by the Plan, to the fullest extent permitted by law. The Plan may proceed against any party with or without the Participant's consent.

12.03 Participant also specifically acknowledges the Plan's right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when the Plan has provided health care benefits for injuries or illness for which another party is or may be responsible and the Participant and/or the Participant's representative has recovered any amounts from the third party or any party making payments on the third party's behalf. By providing any benefit under this SPD, the Plan is granted an assignment of the proceeds of any settlement, judgment or other payment received by the Participant to the extent of the full cost of all benefits provided by the Plan. The Plan's right of reimbursement is cumulative with and not exclusive of the Plan's subrogation right and the Plan may choose to exercise either or both rights of recovery.

12.04 Participant and the Participant's representatives further agree to:

12.04.01 notify the Plan promptly and in writing when notice is given to any third party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by the Participant that may be the legal responsibility of a third party; and

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

12.04.03 give the Plan a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from a third party to the extent of the full cost of all benefits associated with injuries or illness provided by the Plan for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement); and

12.04.04 pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due the Plan as reimbursement for the full cost of all benefits associated with injuries or illness provided by the Plan for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement), unless otherwise agreed to by the Plan in writing; and

12.04.05 do nothing to prejudice the Plan's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery, which specifically attempts to reduce or exclude the full cost of all benefits, provided by the Plan.

12.05 The Plan may recover the full cost of all benefits provided by the Plan under this SPD without regard to any claim of fault on the part of the Participant, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. In the event the Participant or the Participant's representative fails to cooperate with the Plan, the Participant shall be responsible for all benefits paid by the Plan in addition to costs and attorney's fees incurred by the Plan in obtaining repayment.

XIII. DISCLAIMER OF LIABILITY

13.01 Neither AvMed nor the Plan directly employs any practicing Physicians nor any Hospital personnel or Physicians. These health care providers are independent contractors and are not the agents or employees of 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 Participants and are solely responsible for all Medical Services which Participating Providers render to Participants. Therefore, AvMed nor the Plan shall be liable for any negligent act or omission committed by any independent practicing Physicians, nurses or medical personnel, nor any Hospital or health care facility, its personnel, other health care professionals or any of their employees or agents who may, from time to time, provide Medical Services to a Participant. Furthermore, neither AvMed nor the Plan shall be vicariously liable for any negligent act or omission of any of these independent health care professionals who treat a Participant of the Plan.

13.02 Certain Participants may, for personal reasons, refuse to accept procedures or treatment recommended by Participating Physicians. Participating Physicians may regard such refusal to accept their recommendations as incompatible with the continuance of the Physician/patient relationship and as obstructing the provision of proper medical care. If a Participant 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 Participant shall be so advised. If the Participant continues to refuse the recommended treatment or procedure, the Employer may terminate the Participant's coverage under this Plan as set forth in Section 7.01.03.

XIV. REVIEW PROCEDURE

14.01 **Complaints**. Participants have the right to a review of any complaint regarding the services or benefits covered under the Plan. If a Participant has a complaint regarding Plan services, including quality of service, office wait time, Physician behavior and other concerns, the Participant or someone he names to act on his behalf (an authorized representative) may call AvMed's Member Services Department at 1-844-263-2369. AvMed encourages the informal resolution of complaints relating to Plan services, and Member Services Representatives will work with complainants to resolve any such issues over the telephone. If a complainant asks for a written response, or if a complaint is related to quality of care, AvMed will respond in writing. The Member Services Department can also advise how to name an authorized representative.

14.02 **Grievances**. A grievance is any complaint other than one that involves a request (Claim) for benefits, or a request for review of an Adverse Benefit Determination. If a complaint cannot be resolved informally over the telephone, the Participant or his authorized representative may submit the complaint to AvMed, in writing. This is referred to as "filing a grievance". The written grievance will be processed through AvMed's formal grievance procedures.

14.02.01 Grievances must be filed within one year from the date of the event or action that led to the grievance. AvMed will acknowledge and investigate the grievance, and provide a written response advising of the disposition within 60 days after receipt of the grievance. A grievance may be submitted in writing to:

AvMed Member Services – North
P.O. Box 823
Gainesville, Florida 32602-0823
Telephone: 1-844-263-2369
Fax: (352) 337-8612

14.03 **Claims for benefits**. The Employer has delegated to AvMed the discretionary authority to interpret the Plan and to make initial claim determinations. The Employer has delegated to AvMed the discretionary authority to make final internal claim review decisions on appeal. The Employer retains the authority to determine whether employees and their Dependents are eligible to enroll for or continue coverage under the Plan.

14.03.01 **Pre-Service Claims**

a. **Initial Claim**. A Pre-Service Claim for benefits will be deemed to have been filed on the date received by AvMed, on the Plan's behalf. 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 receipt of the Pre-Service Claim.

i. AvMed may extend this period one time for up to 15 additional days, provided that it determines 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 it expects to render a decision. If such an extension is necessary because the Claimant failed to provide sufficient information to decide the Claim, the notice of extension will specifically describe the required information and the Claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

ii. 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 follow in filing a Claim for benefits, not later than five days following such failure.

iii. AvMed's period for making the benefit determination will be tolled from the date the notification of the extension is sent to the Claimant, until the date the Claimant responds to the request for the required information. If the Claimant fails to supply the requested information within the 45-day period, the Claim will be denied.

b. **Appeal**. A Claimant may appeal an Adverse Benefit Determination with respect to a Pre-Service Claim within 180 days of receiving notification of such determination. The Claimant will be notified, in accordance with Section 14.03.07, of the Plan's determination on review within a reasonable period of time, but not later than 30 days after receipt of the appeal. An appeal may be submitted to:

AvMed Member Relations
P. O. Box 749
Gainesville, Florida 32627
Telephone: 1-844-263-2369

Fax: (352) 337-8794

i. If a Claimant wishes AvMed to review a denial prior to filing an appeal, he may call AvMed's Member Services Department at 1-844-263-2369 or submit the request in writing to:

AvMed Member Relations
P.O. Box 749
Gainesville, FL 32602-0749

ii. Additional information may be provided to clarify or support the claim. Persons who were not involved in the initial determination will conduct an internal review. A decision will be made within 30 working days and written notification will be provided to the Claimant. However, this process in no way extends the 180 day appeal period.

c. **External Review**. In the event of a final internal Adverse Benefit Determination with respect to a Pre-Service Claim, a Claimant may be entitled to request that the claim be sent for review by an external reviewer. This request must be received within 180 days of receipt of the Adverse Benefit Determination. The external reviewer will render a recommendation within a reasonable period of time after receipt of the claim, not to exceed 45 calendar days unless the request meets expedited criteria, in which case it will be resolved as soon as administratively possible, but not later than 72 hours. The external reviewer's recommendation will be binding. The external reviewer will notify the Claimant of its decision in writing, and the Plan will take action as appropriate to comply with such recommendation. For further information about the external review process, please contact AvMed's Member Services Department.

14.03.02 **Urgent Care Claims**

a. **Initial Claim**. An Urgent Care Claim for benefits, either oral or written, will be deemed to have been filed on the date it is received by AvMed on the Plan's behalf. AvMed will notify the Claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Urgent Care Claim.

i. If the Claimant fails to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan, AvMed will notify the Claimant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information required to complete the Claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances but not less than 48 hours, to provide the specified information.

ii. AvMed will notify the Claimant of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of AvMed's receipt of the specified information or the end of the period afforded the Claimant to provide the specified information.

iii. If the Claimant fails to supply the specified information within the 48-hour period, the Claim will be denied. AvMed will 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 14.03.05 will be provided to the Claimant no later than three days after the oral notification.

b. **Appeal**. A Claimant may appeal an Adverse Benefit Determination with respect to an Urgent Care Claim within 180 days of receiving notification of such determination. The

Claimant will be notified, in accordance with Section 14.03.07, of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's appeal. The address for submitting an appeal is provided in Section 14.03.01b.

c. **External Review**. In the event of a final internal Adverse Benefit Determination with respect to an Urgent Care Claim, a Claimant may be entitled to request that the claim be sent for review by an external reviewer. This request must be received within 180 days of receipt of the Adverse Benefit Determination. The external reviewer will render a recommendation within a reasonable period of time after receipt of the claim, not to exceed 45 calendar days unless the request meets expedited criteria, in which case it will be resolved as soon as administratively possible, but not later than 72 hours. The external reviewer's recommendation will be binding. The external reviewer will notify the Claimant of its decision in writing, and the Plan will take action as appropriate to comply with such recommendation. For further information about the external review process, please contact AvMed's Member Services Department.

14.03.03 **Concurrent Care Claims**

a. Any reduction or termination of Concurrent Care by AvMed before the end of an approved period of time or number of treatments (other than by Plan amendment or termination), will constitute an Adverse Benefit Determination. AvMed will notify the Claimant, in accordance with Section 14.03.05, 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 final determination on review (including external review), before the benefit is reduced or terminated.

b. With respect to an Urgent Care Claim, any request by a Claimant to extend a course of treatment beyond a previously approved period of time or number of treatments will be decided as soon as possible, taking into account the medical exigencies, and AvMed will notify the Claimant of the benefit determination (whether adverse or not) within 24 hours after receipt of the Claim, provided that any such Claim is made to AvMed at least 24 hours before the expiration of the previously approved period of time or number of treatments. Notification and appeal of any Adverse Benefit Determination with respect to a request to extend a course of treatment, whether involving an Urgent Care Claim or not, will be made in accordance with Sections 14.03.05 through 14.03.07.

14.03.04 **Post Service Claims**

a. **Initial Claim**. A Post-Service Claim for benefits will be deemed to have been filed on the date it is received by AvMed. AvMed will notify the Claimant in accordance with Section 14.03.05, of the benefit determination, within a reasonable period of time but not later than 30 days after receipt of the Post-Service Claim.

i. AvMed may extend this period one time for up to 15 days, provided that it determines 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 it expects to render a decision. If such an extension is necessary because the Claimant failed to provide sufficient information to decide the Claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

ii. AvMed's period for making the benefit determination will be tolled from the date the notification of the extension is sent to the Claimant, until the date the Claimant responds to the request for the required information. If the Claimant fails to supply the requested information within the 45-day period, the Claim will be denied.

b. **Appeal**. A Claimant may appeal an Adverse Benefit Determination with respect to a Post-Service Claim within 180 days of receiving notification of such determination. The Claimant will be notified, in accordance with Section 14.03.07, of the Plan's determination on review within a reasonable period of time, but not later than 60 days after receipt of the Claimant's appeal. The address for submitting an appeal is provided in Section 14.03.01b.

c. **External Review**. In the event of a final internal Adverse Benefit Determination with respect to a Post Service Claim, a Claimant may be entitled to request that the claim be sent for review by an external reviewer. This request must be received within 180 days of receipt of the Adverse Benefit Determination. The external reviewer will render a recommendation within a reasonable period of time after receipt of the claim, not to exceed 45 calendar days unless the request meets expedited criteria, in which case it will be resolved as soon as administratively possible, but not later than 72 hours. The external reviewer's recommendation will be binding. The external reviewer will notify the Claimant of its decision in writing, and the Plan will take action as appropriate to comply with such recommendation. For further information about the external review process, please contact AvMed's Member Services Department.

14.03.05 **Manner and content of initial claims determination notification**. AvMed will provide a Claimant with written notification of any Adverse Benefit Determination. The notification will set forth, in a manner calculated to be understood by the Claimant, the following:

a. Sufficient information to identify the claim, including (as applicable) the date of service, health care provider, and claim amount, as well as notice that the diagnosis and treatment codes along with the corresponding meaning are available upon request and free of charge.

b. The specific reason for the Adverse Benefit Determination including the denial code and its corresponding meaning;

c. A description of the specific benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, and a statement that a copy of such provision, guideline, protocol or other similar criterion will be provided free of charge to the Claimant upon request;

d. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;

e. If the denial decision is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances;

f. 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;

g. A description of appeal rights and AvMed's review procedures and the time limits applicable to such procedures following an Adverse Benefit Determination on final review.

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

14.03.06 **Review procedure upon appeal**. To provide Claimants a full and fair review, AvMed's review process will include the following substantive procedures and safeguards:

a. Claimants may present evidence and testimony, and may submit written comments, documents, records and other information relating to the Claim.

b. Upon request and free of charge, Claimants will have reasonable access to and copies of documents, records, and other information relevant to the claim, and will be permitted to review the Claim file.

c. The review will 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.

d. The review will be conducted by an appropriate named fiduciary of AvMed who is neither the individual nor a subordinate of the individual who made the initial Adverse Benefit Determination. Such person will not be subject to promotion, raises, bonuses, etc. based on whether they approve or deny any claim. Such person will not defer to the initial Adverse Benefit Determination.

e. Review by the appropriate named fiduciary, of any Adverse Benefit Determination based in whole or in part on a medical judgment, including determination as to whether a particular treatment, medication, or other item is Experimental and/or Investigational or not Medically Necessary, will include consultation with a Health Professional who has appropriate training and experience in the field of medicine relevant to the medical judgment.

f. Review will provide 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.

g. The review will provide that the Health Professional engaged for purposes of a consultation as referenced in Section 14.03.06e will be an individual who is neither the individual nor a subordinate of the individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal.

h. In the case of an Urgent Care Claim, there will be an expedited review process available pursuant to which:

   i. Request for an expedited review of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and

   ii. All necessary information, including AvMed's benefit determination on review, will be transmitted between AvMed and the Claimant by telephone, facsimile or other available similarly expeditious methods.

i. If any new or additional evidence considered, relied upon, or generated by or at the direction of the Plan in connection with a claim results in a final internal adverse benefit determination, Claimants will be provided free of charge with such new or additional evidence as soon as possible, and sufficiently in advance of the due date for the notice, so that Claimants have a reasonable opportunity to respond prior to the due date.

j. If a new or additional rationale in connection with a claim results in a final internal adverse benefit determination, Claimants will be provided free of charge with such new or additional rationale as soon as possible, and sufficiently in advance of the due date for the notice, so that Claimants have a reasonable opportunity to respond prior to the due date.

14.03.07 **Manner and content of final review notification**. AvMed will provide a Claimant with written notification of its benefit determination upon review.

a. In the case of a final internal adverse benefit determination, the notification will set forth, in a manner calculated to be understood by the Claimant, all of the following as appropriate:

b. Sufficient information to identify the claim, including (as applicable) the date of service, health care provider, and claim amount, as well as notice that the diagnosis and treatment codes along with the corresponding meaning, are available upon request and free of charge.

c. The specific reason for the Adverse Benefit Determination including the denial code and its corresponding meaning;

d. A description of the specific benefit provision, guideline, protocol or other similar criterion on which the denial decision is based and a discussion of such benefit provision, guideline, protocol or other similar criterion.

e. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;

f. If the denial decision is based on whether the treatment or service is Experimental and/or Investigational or not Medically Necessary, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances.

g. A statement describing any voluntary appeal procedures offered by AvMed and the Claimant's right to obtain the information about such procedures.

14.03.08 If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent 3rd party, who will review the denial and issue a final decision. You may contact AvMed Member Services at 1-844-263-2369 with any questions on your rights to external review. Please understand that if you want to be informed about the legal remedies that may be available to you and whether they are a better option for you than seeking independent external review, you should consult a lawyer of your choice. AvMed cannot provide you with legal advice. We can only explain the procedures for obtaining independent external review.

XV. MISCELLANEOUS

15.01 **Agent for service of legal process**. The name of the person designated as the agent for service of legal process on behalf of the Plan is the Mayor, City of Sunrise, 10770 W. Oakland Park Blvd., Sunrise, Florida, 33351. Additionally, service of legal process may be made on the Plan Administrator.

15.02 **Clerical errors**. Clerical errors shall neither deprive any individual Participant of any benefits or coverage provided under the Plan nor shall such error(s) act as authorization of benefits or coverage for the Participant that is not otherwise validly in force. Retroactive adjustments in coverage, for clerical errors or otherwise will only be done for up to a 60 day period from the date of notification. Refunds of

administrative service fees are done for up to a 60 day period from the date of notification. Refunds of administrative service fees 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.

15.03 **Collective Bargaining Agreement**. If the coverage under the Plan is intended to satisfy a benefit obligation under an applicable collective bargaining agreement, please note that the Plan will govern all benefit determinations and all other determinations under the Plan. The collective bargaining agreement does not influence or control, and is not to be considered to be incorporated with, the Plan in any fashion.

15.04 **Gender**. Whenever used, the singular shall include the plural and the plural the singular and the use of any gender shall include all genders.

15.05 **Identification cards**. Cards issued by AvMed to Participants pursuant to the Plan are for purposes of identification only. Possession of an identification card confers no right to health services or other benefits under the Plan. To be entitled to such services or benefits the holder of the card must, in fact, be a Participant on whose behalf all applicable charges under the Plan have actually been paid and accepted by the Plan.

15.06 **Individual information**. Participants or other individuals shall complete and submit to the Plan such applications, forms or statements as the Plan may reasonably request. If the Participant or other individual fails to provide accurate information that the Plan deems material to providing coverage for such individual, upon ten days written notice, the Plan may deny coverage and/or participation in the Plan to such individual

15.07 **Non-waiver**. The failure of the Plan to enforce any of the provisions of the Plan or to exercise any options herein provided or to require timely performance by any Participant or the Employer of any of the provisions herein, shall not be construed to be a waiver of such provisions nor shall it affect the validity of the Plan or any part thereof or the right of the Plan to thereafter enforce each and every such provision.

15.08 **Plan administration**. The Employer may from time to time adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan.

15.09 **Waiver**. A Claim that has not been timely filed with the Plan within one year of date of service shall be considered waived.

SUMMARY PLAN DESCRIPTION INFORMATION

Official Plan Name:	City of Sunrise Group Medical Plan
Plan Sponsor:	City of Sunrise 10770 W. Oakland Park Blvd. Sunrise, Florida 33351 (954) 572-2496
Plan Administrator:	Risk Manager City of Sunrise 10770 W. Oakland Park Blvd. Sunrise, Florida 33351 (954) 572-2496
Claims Administrator:	AvMed, Inc.
Plan Year:	01/01/2015 – 12/31/2015
Effective Date of the Plan:	01/01/2015
Employer Identification No.:	59-0944587
Plan Type:	Self-insured welfare benefit plan
Source of Funding for the Plan:	The Employer has elected to create a self-insured group medical plan. The Employer has purchased individual and aggregate stop-loss coverage through Symetra.
Sources of Contribution:	Employer and Employees
Agent for Service of Legal Process:	Mayor City of Sunrise 10770 W. Oakland Park Blvd. Sunrise, Florida 33351
Organization that Provides the Benefit:	Benefits under the plan are provided through an Administrative Services Agreement with AvMed, Inc.

SIGNATURE PAGE

CITY OF SUNRISE
PLAN DOCUMENT ACCEPTANCE STATEMENT
FOR THE
POINT OF SERVICE OPTION

City of Sunrise hereby adopts the attached January 2015 Summary Plan Description as the Plan Document of the City of Sunrise Group Medical Plan.

NAME	TITLE	Date
Bill Mason	Risk Manager	7/8/2015
Resolution # 14-107		

NAME TITLE Date

EXHIBIT B. BASIC ADMINISTRATIVE SERVICES AND CHARGES

PART I. BASIC ADMINISTRATIVE SERVICES

A. CLAIM ADMINISTRATION

1. Preparation and delivery of standard claim forms to the Employer for issuance to eligible Participants under the Plan (if necessary);
2. Make initial claim determinations;
3. Investigation of claims, as necessary;
4. Discussion of claims, where appropriate, with providers of health services;
5. Performance of internal audits of claim payments on a random sample basis;
6. Application of claim control procedures necessary to the effective implementation of the basic principles of the Plan;
7. Claim Department consultation, as necessary, with its health care and legal consultants in handling claims. (The Employer will be responsible for seeking its own advice if more specific consultative services are required in a particular case);
8. Calculation of benefits, check preparation, and issuance;
9. Notification to claimants of denials and the reason for the denial;
10. Notification to providers of denied claims, if provider submitted claim directly to Plan for payment, along with the reason for the denial and whether or not the Participant is responsible for payment;
11. Issue certificates of creditable coverage pursuant to the requirements of the Health Insurance Portability and Accountability Act (HIPAA);
12. Coordination with stop loss carrier on aggregate and/or specific stop loss, if purchased;
13. Standard claims and experience reporting;
14. Determination of maximum allowable payment for providers who are not under contract with AvMed;
15. Ad hoc reporting may be available at an additional charge of $150 per hour;
16. Subrogation claims payment (terms described in Part III of this Exhibit);
17. Claim Fiduciary services (including appeals);
18. As requested by Employer, market specific and aggregate reinsurance for Employer's self-funded medical Plans to all reinsurers authorized to administer claims by AvMed and who approve AvMed as a third-party claims administrator. In order for the AvMed to effectively market specific and aggregate reinsurance, Employer shall determine if AvMed's process substantially meets Employer's procurement ordinance requirements. AvMed will market specific and aggregate reinsurance at no cost to Employer. If approved to market Employer's specific and aggregate reinsurance, Employer will agree to authorize AvMed to release minimally necessary underwriting data, and AvMed will agree to cooperate and share responses from the market with Employer, Employer's benefits consultant and Employer's actuary in order to properly evaluate the proposals.

B. CLAIMS RUN-OUT UPON AGREEMENT TERMINATION

1. Upon termination of this Agreement, AvMed will continue to process and review claims incurred during the contract period for up to twelve (12) months. Because AvMed will not relinquish the administration of its provider network contracts to a third party, AvMed agrees to receive, process, and review claims

from AvMed contracted providers for at least six (6) months and not greater than 12 months following the termination of this Agreement. The Employer is expected to fund the claims presented by AvMed within the same timeframes as agreed to for claims paid during this Agreement period. If this agreement terminates due to non-funding of claims, bankruptcy or other reasons stated in Section 4.02.04, AvMed may notify the healthcare providers as to a revised process for obtaining payment. AvMed will charge an additional claims administration fee of $66.70 per Subscriber for providing this service.

2. Upon termination of this Agreement, claim information will be furnished to Employer for the standard run-out period addressed in the Agreement and to the extent administratively feasible based on the standard reporting package provided to the Employer before the Agreement was terminated.

C. FINANCIAL

1. Provision of various modes agreed upon between Employer and AvMed for invoices for various service fees, administrative fees, and reinsurance premiums:

2. Disbursement of various modes of payments agreed upon between Employer and AvMed for reinsurance premiums, administrative fees, claim expenses or service fees, etc. to enable continuous provision of services and coverage:

3. Provision of annual year-end accounting consisting of a summary of the amount of paid claims at the coverage level and a summary of charges paid.

4. At the Employer's request, AvMed agrees to bill and include the specific and aggregate reinsurance costs to the monthly administration fee per Subscriber per month. The specific and aggregate reinsurance costs shall be allocated on a monthly rate basis per single and family tier of coverage under the Plan, unless requested otherwise by Employer in writing to AvMed no less than sixty (60) days prior to the annual anniversary date of the Plan.

5. AvMed agrees to credit the Account with any and all pharmacy rebates in accordance with EXHIBIT G. Prescription Drug Discounts and Rebates within approximately six (6) months after the end for the first quarter starting of Plan, and thereafter, credit Employer with subsequent pharmacy rebates on a routine quarterly basis.

D. BANKING AND ADMINISTRATION

1. Furnishing of bank account activity data (to the extent administratively reasonable) to Employer based on the following frequency:

   a) AvMed agrees to send Employer a funding request for medical and pharmacy claims by the end of the business day of each Monday.

   b) AvMed agrees to provide Employer with a monthly bank reconciliation report.

2. Preparation for Employer of information reports required in connection with claim payments under the Plan to providers of health care services pursuant to Section 6041 of the Internal Revenue Code (Form 1099).

3. Provision of data maintained by AvMed for Employer's preparation of required governmental filings, upon request.

4. Employer agrees to open a depository account in Employer's name ("Employer's Depository Account"), and AvMed agrees to open a disbursement account AvMed's name ("Account"), which will draft out of the Employer's Depository Account. This funding methodology may be changed if mutually agreed to by Employer and AvMed, to be in the best mutual interest of Employer and AvMed. Employer agrees to provide AvMed with the necessary signature authority. As necessary, AvMed and Employer will share banking forms with the other prior to requesting execution. Employer and AvMed agree to execute the necessary banking forms.

5. Employer agrees to maintain a zero balance account method for Employer's Depository Account on a daily basis, but no less than weekly. Employer reserves the right to fund such account and/or reserve account in amount as set forth by Employer's actuary provided it meets the minimum funding requirements for the working deposit in Section 7.04 in the Agreement.

6. AvMed agrees to reconcile the check register utilized to prepare the funding report request on weekly basis.

7. AvMed will notify Employer of any unusually large claims that may exceed the working deposit amount maintained by Employer in the depository account. Such unusually large claims may also be disclosed and noticed on the funding report request every Monday from AvMed to Employer.

8. AvMed agrees to email the weekly funding report request to the following four (4) staff of Employer:

   a) Bill Mason, Risk Manager, at bmason@sunrisefl.gov

   b) Osh Mason, Assistant Risk Manager, at omason@sunrisefl.gov

   c) Jack Lazarowitz, Treasury Manager, at jlazarowitz@sunrisefl.gov

   d) Rita Henderson, Accountant, at rhenderson@sunrisefl.gov

   Employer can update list of staff by giving email notice to AvMed.

E. NETWORK ACCESS

1. Access to the AvMed Exclusive Provider Network, which may change from time to time.

2. Access to a national provider network that shall be available to retirees or other Participants living outside the AvMed service areas, or eligible for Plan coverage under AvMed's Away from Home Program.

3. Provide Employer a listing of participating providers. Such listing will include the names, specialties, addresses, and phone numbers of such providers. An updated listing will be posted on AvMed's website at www.avmed.org.

4. Access to a transplant network.

5. Provide Employer with a provider directory, as requested, for eligible Participants at the initial enrollment and provide Employer a reasonable supply of provider directories upon each reprint for distribution to new enrollees in the Plan.

6. Employer understands that AvMed may not contract for all services offered by a participating provider. It is the responsibility of the Participant to verify that the specific services are covered by both the Plan and AvMed's contract with the participating provider.

7. Network management services which include credentialing and re-credentialing of providers, contract negotiations and provider servicing.

8. Provide one identification card for each Participant upon enrollment and subsequently if there is a material change in benefits, a qualified event, or request by Employer or Participant. Subject to mutual agreement by the Parties on the charge that will be paid by Employer to AvMed, AvMed will reissue cards at other mutually agreed upon times, such as for mass re-carding by Employer.

F. MEDICAL MANAGEMENT

1. AvMed will provide utilization review programs to include:

   a) prior authorization of all inpatient and certain outpatient and office procedures.

   b) concurrent review of inpatient stays, (either on-site or telephonically).

c) Service plus program which provides nurses and other medical staff available to all providers 24 hours a day, 7 days a week.

d) Discharge planning.

2. AvMed will provide:

a) Nurse helpLine, which is staffed 24 hours a day, 7 days a week to provide immediate information to Participants by either talking to a nurse or listening to pre-recorded informational health topics.

b) Complex case management, when appropriate.

c) High tech radiology procedure review.

d) Alere NICU Program which monitors high risk newborns for a per case fee up to $1,500 billed through weekly claims fund request.

3. AvMed will provide transplant coordination and management to Participants, upon notice.

4. Disease management services are available from an AvMed partner on a per care support member per month fee basis. The following table lists the fees associated with this service:

a) Employer purchased the core conditions at the following rates, which will be billed in accordance with EXHIBIT F:

G. COMPREHENSIVE ACCOUNT AND MEMBER SERVICE

1. Enrollment and case installation
2. Designated Account Service Team
3. Member Service Staff available via dedicated toll free telephone number
4. On-site Service Representative.
5. Distribution of notices to Participants from time to time to improve Plan administration or as required by law. Notices specific to the Plan, federal or state law, will be submitted to the Employer for review prior to distribution to Subscribers, and Participants when applicable. Employer and AvMed will mutually agree to draft and distribute notices provided in the manner required by federal and state law in accordance with Attachment #1 Group Health Plans' Notification Checklist attached to this exhibit, including any subsequent additional notices required by federal or state law.
6. Creation and maintenance of a basic Summary Plan Description.
7. Printing of Exclusive Provider Network (HMO) Summary Plan Document and Point of Service (POS) Summary Plan Document at a cost of $1.25 per Summary Plan Document. AvMed shall provide Employer an electronic copy in PDF format of both the Exclusive Provider Network (HMO) Summary Plan Document and Point of Service (POS) Summary Plan Document at no cost.

H. ELIGIBILITY

1. Screening of enrollment requests for dependent coverage in accordance with the Plan. This screening may include requests for marriage licenses, adoption papers, and birth certificates, as well as requests for documentation supporting student status or financial dependency.
2. Periodic screening for continued Covered Dependent eligibility.
3. Performance of COBRA Continuation Coverage administration through an AvMed business partner.

I. OTHER SERVICES

1. Worksite Wellness Program Coordination, upon request from Employer. Employer agrees to fund actual cost of delivering the requested services (e.g. massage therapy; flu shot administration, health screenings, etc.). AvMed agrees to administer employer-funded incentive programs. AvMed will allocate twenty-five thousand dollars ($25,000) annually to a wellness fund that can be used at the Employer's discretion. Funds can roll-over from year to year.
2. Access to the Healthways WholeHealth network and transitioning in first quarter of 2015 to the Affinity program - ChooseHealthy through American Specialty Health (Healthyroads) which provides a list of holistic providers at a discounted rate.
3. Upon request from Employer, AvMed agrees to administer the Weight Watchers program reimbursement, according to AvMed's standard program criteria. Should any Participant achieve goal weight, AvMed will include the request for funds on a weekly claim funding report to the Employer. Once funds are received, AvMed will issue a check for reimbursement of a portion of the program fees to the Participant.
4. AvMed will perform hospital and physician bill auditing as part of AvMed's standard program. AvMed agrees to return savings generated through the audit process to Employer for a fee of (twenty-five percent (25%) of savings.
5. AvMed will make available, on the AvMed website, the Health Risk Assessment tool for Employer's Participants.
6. AvMed agrees to return savings generated through the subrogation process to Employer with a fee of twenty-five percent (25%) of subrogation recovery amount.

PART II. CHARGES FOR BASIC ADMINISTRATIVE SERVICES PROVIDED BY AVMED OR A SUBCONTRACTOR

A. BASIC ADMINISTRATIVE SERVICES

1. **AvMed**

Contract Years: Year 1 through Year 3: January 1, 2015 through December 31, 2017 the mutually negotiated and agreed upon administrative fee shall be $38.00 per Subscriber per month (PSPM) in accordance with EXHIBIT F. Third-Party Administrative Cost Form. Any new administrative fee shall be negotiated and mutually agreed upon by Employer and AvMed, and will be provided by way of amendment to any applicable Extended Contract Years.

Extended Contract Years: Year 4: January 1, 2018 through December 31, 2018 Fee increase not to exceed 3%, per Subscriber per month (PSPM) as negotiated and mutually agreed upon between Employer and AvMed. Any change in any administrative fee will be provided for by way of amendment to this Agreement between Employer and AvMed.

Extended Contract Years: Year 5: January 1, 2019 through December 31, 2019 Fee increase not to exceed 3%, per Subscriber per month (PSPM) as negotiated and mutually agreed upon between Employer and AvMed. Any change in any administrative fee will be provided for by way of amendment to this Agreement between Employer and AvMed.

2. Employer and AvMed agree each liquidated damage in accordance with EXHIBIT E. Performance Guarantees is independent of any other when calculated, and will be applied against AvMed's administrative fee as provided above in Contract Years: Year 1 through Year 3, including Extended Contract Years: Year 4 and Year 5. **Capitation Fees Billed by AvMed on Behalf of Provider Vendors**

In lieu of medical claims, fixed expenses will include the capitation per Participant per month to provider vendors, as per the terms of the AvMed contract with the provider. Capitation vendors, services, and rates may change throughout the contract year (the period of 12 consecutive months commencing on the effective date of the Agreement) based on AvMed's commercial block of business. The rate is subject to

change as AvMed's rate is adjusted throughout the year and is subject to the provisions of Section XII (Modification of Plan and Administrative Duties and Charges) of this Agreement.

3. **Participating Providers Rates**

   Each AvMed Participating Provider in the Self-funded network has agreed to accept contractual and negotiated rates as payment in full for services rendered to the Employer's Participants who are covered under the Plan, provided claims are funded by the Employer as soon as presented for payment. Participating providers expect to receive payment of the required deductibles, co-payments and co-insurance, as outlined in the schedule of benefits, from the Participants at the time the service is rendered.

4. **MultiPlan, Inc.**

   a) Under the Exclusive Provider Network (HMO) Summary Plan Document or Point of Service (POS) Summary Plan Document offered by Employer, AvMed has arranged with MultiPlan, Inc. to offer its various networks, including the PHCS Healthy Directions Network, to serve as wrap-around networks for medical care under the Plan provided outside of the AvMed Service Area when Participants who reside in the AvMed Service Area travel for covered medical services, or reside outside the AvMed Service Area on a permanent or temporary basis. Therefore, AvMed is making this benefit available to the Plan for any claims that may fall within the parameters of AvMed's agreement with MultiPlan, Inc. The fee for this service is 30% of savings (billed charges less contracted amount). AvMed has also entered into contracts with third-parties that may provide a negotiated savings on hospital and other medical services covered under the Plan. Use of these additional AvMed contractual arrangements will provide additional savings and broader network for Participants covered under Employer's Plan.

PART III. CONDITIONAL CLAIM/SUBROGATION RECOVERY SERVICES

A. All conditional claim payment and/or subrogation recoveries under the Plan will be handled by the entity checked below:

	EMPLOYER
	AN INDEPENDENT RECOVERY VENDOR WHOSE NAME AND ADDRESS FOLLOW:
	_____
	_____
X	**AVMED & ITS SUBCONTRACTOR(S)**

B. If Employer has designated AvMed and its subcontractors to act as its recovery agent in Paragraph A above; then:

1. Employer hereby confers upon AvMed and its subcontractors discretionary authority to reduce recovery amounts per AvMed's standard operating procedure of the total amount of benefits paid on Employer's behalf, and to enter into binding settlement agreements for such amounts.

2. All subrogation and/or reimbursement recovery functions under the Plan will be handled by AvMed.

3. In accordance with state law restrictions, AvMed shall have no duty or obligation to represent Employer in any litigation or court proceeding involving any matter which is the subject of this Agreement, but shall make available to Employer and/or Employer's legal counsel such information relevant to such action or proceeding as AvMed may have as a result of its handling of any matter under this Agreement.

4. AvMed agrees to return savings generated through the subrogation process to Employer for a fee of twenty-five percent (25%) of subrogation recovery amount.

OPT-OUT

_____ Employer does not confer subrogation/reimbursement recovery responsibilities to AvMed. AvMed will only be responsible for providing the Employer with claims information pertinent to subrogation and reimbursement cases upon request. Employer will perform all subrogation/reimbursement functions.

(REMAINDER OF PAGE INTENTIONALLY LEFT BLANK)

ATTACHMENT #1 GROUP HEALTH PLANS' NOTIFICATION CHECKLIST

The notices below will be drafted and distributed in the manner required by federal and state law:

Name:	Employee Notice of Coverage Options
Entity That Provides Notice:	Employer
Name:	Notice of Creditable Coverage (Medicare Part D)
Entity That Provides Notice:	Employer
Name:	Group Health Plan Report for IRS/SSA/CMS Data Match
Entity That Provides Notice:	Employer
Name:	Consolidated Omnibus Budget Reconciliation Act (COBRA)
Entity That Provides Notice:	AvMed
Name:	Notice of Unavailability of Continuation Coverage under COBRA
Entity That Provides Notice:	AvMed
Name:	COBRA Election Notice
Entity That Provides Notice:	AvMed
Name:	Notice of Insufficient Payment of COBRA Premium
Entity That Provides Notice:	AvMed
Name:	Summary of Benefits and Coverage (SBC) & Uniform Glossary
Entity That Provides Notice:	Employer
Name:	Notice of Change to SBCs (Notice of Material Modifications)
Entity That Provides Notice:	Employer
Name:	Women's Health and Cancer Rights Act (WHCRA) Notices
Entity That Provides Notice:	AvMed
Name:	Notice of Special Enrollment Rights
Entity That Provides Notice:	AvMed
Name:	Wellness Program Disclosure
Entity That Provides Notice:	Employer
Name:	Summary Plan Descriptions (SPDs)
Entity That Provides Notice:	AvMed
Name:	Summary of Material Reduction in Covered Services or Benefits
Entity That Provides Notice:	Employer
Name:	Breach Notification for Unsecured PHI
Entity That Provides Notice:	Employer, AvMed or any Business Associate.
Name:	Report of Minimal Essential Coverage
Entity That Provides Notice:	Employer

EXHIBIT C. CLAIM PAYMENT OR OVERPAYMENT RECOVERY

If a claim is paid and it becomes necessary to re-claim all or part of the funds from the Participant, AvMed will contact the Participant in writing to request reimbursement of these funds. If there is no response within thirty (30) days, AvMed will notify the Employer who will then either handle the recovery themselves OR allow AvMed to use its contracted collection agency to try to recover funds on their behalf. The cost of this collection agency is approximately twenty-five percent (25%) of collected funds and is the responsibility of the Employer.

Employer should indicate which method of collection is required:

A) Employer handles recovery in all cases

X. B) AvMed refers all cases to collection

EXHIBIT D. CONFIDENTIALITY AGREEMENT

This Agreement effective the 1st of January, 2015 is by and between City of Sunrise (Employer)and AvMed, Inc. d/b/a AvMed, for itself and its affiliated companies (AvMed).

WHEREAS, AvMed and Employer have entered into an Administrative Services Agreement (Agreement) pursuant to which AvMed administers claims for benefits under Employer's employee group medical plan under EXHIBIT A of the Agreement (the 'Plan'); and

WHEREAS, in its role as claims administrator for the Employer, AvMed has come into possession of certain individually identifiable records and other information including, but not limited to, information relating to claims for benefits under the Plan (collectively 'Information'); and

WHEREAS, Employer desires that Information in the possession of AvMed be made available to it and to certain designated third parties ("Designated Third-Parties") who assist it in administering the Plan. Such Designated Third-Parties may include, but are not limited to, a third-party administrator, benefit consultant, actuary, health care counsel, regulatory compliance consultant, brokers, auditor, successor administrators or insurers, and stop-loss carriers.

WHEREAS, AvMed desires, to the extent allowable by state law and by the Health Insurance Portability and Accountability Act, to accommodate Employer's request;

WHEREAS, Employer recognizes the confidential nature of Information that it has requested; and

WHEREAS, Employer recognizes AvMed's legitimate interest in maintaining the confidentiality of Information and in protecting itself from any and all legal liability with respect thereto;

NOW, THEREFORE, in consideration of the premises and the mutual promises contained herein, AvMed and Employer hereby agree as follows:

1. AvMed will provide to Employer Information requested in writing by a person designated in writing by Employer to receive Information. Employer acknowledges that in receiving Information under the terms of this Agreement, Employer acts in its capacity as Plan Administrator. Information will be used by Employer for the purpose of satisfying its fiduciary responsibilities with respect to administration of the Plan, and will be handled and maintained in accordance with all fiduciary obligations owed by Employer to Participants.

   Upon Employer's written request, AvMed will provide to Designated Third-Parties Information requested in writing by a person designated in writing by Employer to receive such Information. Employer acknowledges that in directing AvMed to give information to Designated Third-Parties, Employer acts in its capacity as Plan Administrator. Information will be used by Designated Third-Parties for the sole purpose of assisting Employer in satisfying its fiduciary responsibilities with respect to administration of the Plan, and will be handled and maintained in accordance with all fiduciary obligations owed by Employer to Participants.

2. Employer acknowledges that AvMed is providing Information to Employer or to Designated Third - Parties solely for the purposes stated in paragraphs 1 and 2 above.

3. Employer will not provide access to Information to any employee, agent or other designee other than an employee, agent or designee with a need-to-know such information who is designated by Employer to participate in the activities described in paragraph 1 above and who has the requisite expertise and responsibility to engage in such activities.

4. Employer will maintain and adhere to a written policy and procedure designed to protect the confidentiality of Information.

5. Employer agrees to keep all Information that pertains to individual Participants confidential in accordance with all applicable state and federal laws and regulations.

6. Unless otherwise provided for in the Agreement, Employer will defend, indemnify and hold AvMed harmless from and against any and all claims, suits, expenses (including reasonable attorney's fees and court costs), liabilities or damages (whether resulting from settlement, judgment, arbitration or otherwise) arising directly or indirectly from the unlawful use or disclosure of Information or protected health information (PHI) by the Employer or Designated Third-Parties. In the event there is a conflict between the indemnification under Exhibit D. Confidentiality Agreement and the Administrative Service Agreement, then the Agreement's indemnification provisions shall govern.
7. This Confidentiality Agreement shall remain in force until it is terminated upon sixty (60) days prior written notice by Employer or AvMed. However, termination shall not in any way affect Employer and AvMed's obligations with respect to Information released under this Confidentiality Agreement prior to termination nor shall it affect the indemnification provision set forth above in paragraph 6, which also shall survive the termination of this Confidentiality Agreement.

IN WITNESS WHEREOF, the Employer and AvMed hereto have caused this Agreement to be executed by their duly authorized officers.

AvMed, Inc. (AvMed)

By: James Repp

Title: Sr. Vice President, Member Relationship Management

Signature

Date: 7/17/2015

Address: 9400 S. Dadeland Blvd.

Miami, FL 33156

Facsimile: (305) 671-4764

Email: jim.repp@avmed.org

City of Sunrise (Employer)

By: Bill Mason

Title: Risk Manager

Signature Resolution #14-07

Date: 7/8/2015

Address: City of Sunrise, Risk Management Division

10770 W. Oakland Park Blvd, 3rd Floor

Sunrise, FL 33351

Facsimile: (954) 572-2382

Email: bmason@sunrisefl.gov

EXHIBIT E. PERFORMANCE GUARANTEES

Each liquidated damage is independent of any other when calculated and applied against AvMed's administrative fee provided for under the Exhibit B, Part II, Charges for Basic Administrative Services provided by AvMed or a subcontractor, Section A. Basic Administrative Services. Employer and AvMed agree that the amount of damages is incapable of precise determination. As a result, Employer and AvMed have agreed to these liquidated damages, and agreed they are not a penalty. Employer and AvMed agree that payment of the applicable percentage of the administrative fee shall constitute the exclusive remedy for failure to meet a Performance Commitment and the failure to meet the Performance Commitment shall not constitute a breach of the Agreement.

Implementation Performance Guarantees	Performance Commitment	Liquidated Damages % Amount
Identification Card Delivery Performance Standard	98% of Identification Cards mailed within 10 business days of receipt of complete and accurate eligibility data.	1% of annual Administrative Fee
Call Readiness Performance Commitment	Service Center(s) ready to respond to customer inquiries as of Plan effective date.	1% of annual Administrative Fee
Overall Satisfaction with Implementation Services Performance Standard	Based on a mutually agreed upon Satisfaction Survey (standard will be measured and reported to Employer annually after open enrollment implementation).	1% of annual Administrative Fee

Ongoing Performance Guarantees	Measure Method	Liquidated Damages % Amount
I.D. Card Production (ongoing)	98% of Identification Cards mailed within 10 business days of receipt of complete and accurate eligibility data (standard will be measured and reported to Employer quarterly).	1% of annual Administrative Fee
Claims Processing	Time to Process: 94% of claims processed in 10 business days from the date a claim is received to the date it is processed (i.e., paid, pended or denied) excluding weekends and holidays (clean claims only). Standard will be measured and reported to Employer quarterly. Financial Accuracy: 98% Financial Accuracy (Defined as claim dollars paid correctly divided by claim dollars paid based on all claims in the audit sample. Claim dollars paid	1% of annual Administrative Fee 1% of annual Administrative Fee

Ongoing Performance Guarantees	Measure Method	Liquidated Damages % Amount
	correctly are calculated by subtracting gross, not net, payment errors from total claim dollars paid.) (standard will be measured and reported to Employer quarterly). Procedural Accuracy: 98% (Defined as number of correct claims reviewed in the audit sample divided by the total number of claims reviewed in the audit sample. A "correct claim" is free of any errors including, but not limited to, spelling, coding, financial, typographical, or numerical (standard will be measured and reported to Employer quarterly).	1% of annual Administrative Fee
Member Services Hold Time Abandonment Rate Average Speed of Answer	Toll-free telephone line: Established and operational 30 days prior to the effective date of plan and 95% functional at all times. Standard will be measured and reported to Employer quarterly. Average Speed of Answer: Guarantee that 80% of calls answered within 30 seconds or less (standard will be measured and reported to Employer quarterly) Abandonment Rate: Guarantee that the call abandonment rate will be 4% or less (standard will be measured and reported to Employer quarterly).	1%of annual Administrative Fee 1% of annual Administrative Fee 1% of annual Administrative Fee
Transition of Care	Once members are identified, outreach will be made within 10 business days or the close of open enrollment. After open enrollment, AvMed guarantees outreach within 4 business days.	1% of annual Administrative Fee

EXHIBIT F. THIRD PARTY ADMINISTRATION COST FORM

AvMed fully identifies all administrative cost factors of the services rendered under this Agreement on this form, unless otherwise provided in the Agreement. AvMed agrees these administrative fees are inclusive of all cost and unforeseen supplemental fees shall be minimal; otherwise, Employer's approval will be necessary in writing as required in the Agreement. AvMed provides these fees on a per Subscriber per month basis (PSPM), unless otherwise noted below. AvMed guarantees these rates for three (3) years from the effective date of this Agreement.

Requested Services	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Claims Administration*	$19.88	$19.88	$19.88		
Utilization Management & Review Fees	$5.60	$5.60	$5.60		
Medical Case Management	$2.38	$2.38	$2.38		
Network Access Fee	$3.44	$3.44	$3.44		
Other Network Administration Fees	$3.68	$3.68	$3.68		
Disease Management Fees (list all programs currently offered to ASO accounts)**					
Cardiovascular	$143.21 PP	$143.21 PP	$143.21 PP		
Diabetes	$110.79 PP	$110.79 PP	$110.79 PP		
Coronary Artery Disease	$87.75 PP	$87.75 PP	$87.75 PP		
COPD	$96.32 PP	$96.32 PP	$96.32 PP		
Asthma	$47.37 PP	$47.37 PP	$47.37 PP		
Other (please list): Low Risk/Education	$1.55 PP	$1.55 PP	$1.55 PP		
Wellness Services					
Health Risk Assessments (online)	Included	Included	Included		
Biometric Screenings (price based on screening type)	Variable	Variable	Variable		
Incentive Administration (price based on program selection)	Variable Included	Variable Included	Variable Included		
Standard Reports	Included	Included	Included		
Capitated Services* **					
Lab	$2.44	$2.44	$2.44		
Durable Medical Equipment	$2.39	$2.39	$2.39		
Home Health and Home Infusion	$2.25	$2.25	$2.25		
Fiduciary Services - coordination of benefits, claim appeals	$1.00	$1.00	$1.00		
On-Site Service Representative	Included	Included	Included		
Other Fees That May Be Included Above					
Start-up fees	Included	Included	Included		
Preparation of summary plan descriptions	Included	Included	Included		

ID cards	Included	Included	Included		
Other (please list) HIPAA Certificates	$0.25	$0.25	$0.25		
COBRA Administration	$0.40	$0.40	$0.40		
Nurse Help Line	$1.37	$1.37	$1.37		

NOTES:

*The Claims Administration fee has been rounded by $0.01 to reflect the request for proposals' agreed Total Administrative fee of $38.00 per Subscriber per month (PSPM).

**Disease Management fees are listed as per program enrolled Participant, and are not included in the Total Administrative Fee PSPM.

***Capitated Services Rates are representative of current per Member per month (PMPM) capitation rates for the amount shown. They are subject to change as provider agreements are negotiated, and are billed on a PMPM basis.

EXHIBIT G. PRESCRIPTION DRUG DISCOUNTS AND REBATES

AvMed's prescription drug discounts and rebate information are shown below:

Broad Retail Network (List any Major Retail Chains Excluded)	Standard AWP Discount Retail Supply ≤ 30	Standard AWP Discount Retail Supply >30	Standard AWP Discount Mail Order
Brand Drugs			
Single source discount from 100% AWP	16%	19%	23%
Multi-source discount from 100% AWP	16%	19%	23%
Composite Brand discount from 100% AWP	16%	19%	23%
Dispensing Fee/Rx	1.00	1.00	0.00
Guaranteed Rebate Per Rx (% rebate subject to $x.xx minimum)	$35 Per Brand Rx	$90 Per Brand Rx	$105 Per Brand Rx
Generic Drugs			
Composite discount from AWP of all generics (composite of MAC prices, discounted AWP, or usual and customary retail price)	78%	79.5%	81%
MAC Guarantee			
Dispensing Fee/Rx	1.00	1.00	0.00

EXHIBIT H. CLAIM AUDIT AGREEMENT

WHEREAS, AvMed, Inc. d/b/a AvMed desires to cooperate with requests by City of Sunrise ("Employer") to permit an audit for the purposes set forth below; and

WHEREAS, _____("the Auditor") has been retained by Employer for the purpose of performing an audit ("Audit") of claims administered by AvMed.

WHEREAS, AvMed and Employer shall agree to execute this Claim Audit Agreement as to form with the Auditor to be determined by Employer.

WHEREAS, Employer shall notify AvMed no less than sixty (60) days after an Auditor is retained and Employer agrees to this Claim Audit Agreement, which shall be EXHIBIT H and incorporated into the Agreement between Employer and Auditor.

WHEREAS, Employer, AvMed, and Auditor, when retained, shall agree to execute this Claims Audit Agreement and provide original executed copies to Employer, AvMed and Auditor.

WHEREAS, the Auditor and the Employer recognize AvMed's legitimate interests in maintaining the confidentiality of its claim information, protecting its business reputation, avoiding unnecessary disruption of its claim administration, and protecting itself from legal liability;

NOW THEREFORE, IN CONSIDERATION of the premises and the mutual promises contained herein, AvMed, the Employer and the Auditor hereby agree as follows:

A. Audit Specifications

The Auditor will specify to AvMed in writing at least 30 days prior to the commencement of the Audit the following "Audit Specifications":

1. the name, title and professional qualifications of individual Auditors;
2. the Claim Office locations, if any, to be audited;
3. the Audit objectives;
4. the scope of the Audit (time period and number of claims);
5. the process by which claims will be selected for audit;
6. the records/information required by the Auditor for purposes of the Audit; and
7. the length of time contemplated as necessary to complete the Audit.

B. Review of Specifications

AvMed will have the right to review the Audit Specifications and to require any reasonably necessary changes in, or conditions on, the Audit Specifications which may be necessary to protect AvMed's legal and business interests identified in paragraph A. Audit Specifications above.

C. Access to Information

AvMed will make the records/information called for in the Audit Specifications available to the Auditor at a mutually acceptable time and place.

D. Audit Report

The Auditor will provide AvMed with a true copy of the Audit's findings, as well as of the Audit Report, if any, that is submitted to the Employer. Such copies will be provided to AvMed, within five (5) days after Employer has completed its review of the draft Audit Report presented by the Auditor and a final Audit Report has been issued by the Auditor.

E. Comment on Audit Report

AvMed reserves the right to provide the Auditor and the Employer with its comments on the findings and, if applicable, the Audit Report.

F. Confidentiality

The Auditor understands that AvMed is permitting the Auditor to review the claim records/information solely for purposes of the Audit. Accordingly, the Auditor will ensure that all information pertaining to individual claimants will be kept confidential in accordance with all applicable laws and/or regulations. Without limiting the generality of the foregoing, the Auditor specifically agrees to adhere to the following conditions:

1. The Auditor shall not make photocopies or remove any of the claim records/information without the express written consent of AvMed;

2. The Auditor agrees that its Audit Report or any other summary prepared in connection with the Audit shall contain no individually identifiable information.

G. Restricted Use of the Audit Information

With respect to persons other than the Employer, the Auditor will hold and treat information obtained from AvMed during the Audit with the same degree and standard of confidentiality owed by the Auditor to its clients in accordance with all applicable legal and professional standards. The Auditor shall not, without the express written consent of AvMed executed by an officer of AvMed, disclose in any manner whatsoever, the results, conclusions, reports or information of whatever nature which it acquires or prepares in connection with the Audit to any party other than the Employer except as required by applicable law. The Auditor agrees to indemnify and to hold harmless Employer and AvMed for any and all claims, costs, expenses and damages which may result from any breaches of the Auditor's obligations under paragraph A. Audit Specifications above of this Agreement or from Employers and AvMed's provision of information to the Auditor.

H. Expenses Incurred

Expenses incurred in performing the Audit will be the responsibility of the Employer.

I. Termination

AvMed may terminate this Agreement with prior written notice. The obligations set forth in paragraph A. Audit Specifications above shall survive termination of the Agreement.

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AvMed, Inc. (AvMed)
By: James Repp
Title: Sr. Vice President, Member Relationship Management
Date: 7/17/2015
Address: 9400 S. Dadeland Blvd.
Miami, FL 33156
Facsimile: (305) 671-4764
Email: jim.repp@avmed.org

Signature

City of Sunrise (Employer)
By: Bill Mason
Title: Risk Manager
Date: 7/8/2015
Address: City of Sunrise, Risk Management Division
10770 W. Oakland Park Blvd, 3rd Floor
Sunrise, FL 33351
Facsimile: (954) 572-2382
Email: bmason@sunrisefl.gov

Signature RESOLUTION # 14-107

To Be Determined (TBD) (Auditor)
By: (TBD)
Title: (TBD)
Date: (TBD)
Address: (TBD)
Facsimile: (TBD)
Email: (TBD)