Health First
Health Plans

6450 US Highway 1
Rockledge, Florida 32955
myHFHP.org

Lyn Sevin
Brevard Workforce
297 Barnes Blvd
Rockledge, FL 32955

Dear Valued Member,

Thank you for choosing Health First Health Plans. At Health First Health Plans, we believe in helping you navigate your benefits and giving you the tools to better understand your plan.

Enclosed you will find your plan documents. These documents include information on your health plan's guidelines, benefits, and member responsibilities including covered and non-covered services in your plan.

Members have access to a secure member portal where benefits, claims, authorizations and deductible or out-of-pocket maximums can be viewed. You'll also have access to health information, health coaching, disease management and wellness materials. It is easy to set up your member portal – you will just need your member ID number and your personal information.

Materials such as your member handbook, rights and responsibilities, provider directory or other information can be viewed and printed by visiting our website at myHFHP.org.

If you have questions about your plan or need assistance in a language other than English, please call Customer Service at or 1.855.443.4735 (TTY/TDD relay: 1.800.955.8771) Monday through Friday from 8 a.m. to 6 p.m.

Thank you and we look forward to serving your health coverage needs.

Sincerely,

Health First Health Plans

HEALTH FIRST HEALTH PLANS, INC.
6450 US HIGHWAY 1
ROCKLEDGE, FL 32955

Please call (855) 443-4735 for assistance regarding claims and information about coverage

Florida Small Group Health Benefit Plan

(Herein called the Group Plan)

Brevard Workforce

(Herein called the "Small Employer")

Health First Health Plans, (hereinafter called the Health Plan), agrees to provide the health care services described under the provisions of this Group Plan to all Covered Employees of the Small Employer and their Covered Dependents. The provision of services is subject to all of the terms on this page and those that follow, including any limitations, restrictions or exclusions, as well as any amendments that may be made a part of this Group Plan.

The Small Employer may act on behalf of all eligible employees and their eligible dependents for the purpose of administering this Group Plan. Every act by, agreement made with, or notice given to the Small Employer will be binding on all Covered Employees and Dependents.

This Group Plan is issued in consideration of the application of the Small Employer and payment of Premium in advance by the Small Employer at the Health Plan's corporate office in Rockledge, Florida.

This Group Plan is effective on the Group Effective Date shown on the Group Plan Information Page. The first Premium covers the period starting on the Group Effective Date.

Signed for the Health Plan at its corporate office in Rockledge, Florida to take effect on the Group Effective Date for delivery in the State of Florida.

CEO
Health First Health Plans, Inc.

GROUP POLICY INFORMATION PAGE

Small Employer Name	Brevard Workforce
Medical Benefit	SG Value Choice POS Option VC1 Rx $2/15/30/50/20%
Group Policy Number	114168
Group Effective Date	1/1/2020
Group Policy Anniversary Date	1/1/2021
Eligible Class(es) of Employees	Active/COBRA (Retirees, as determined by employer)
Waiting Period	First of the month after date of hire As determined by employer (cannot exceed 90 days)

Group Premium Classes

Employee Only	$ 775.72
Employee plus Spouse	$ 1,667.81
Employee plus Child(ren)	$ 1,489.39
Employee, plus Family	$ 2,327.17

RESPONSIBILITIES OF THE SMALL EMPLOYER
The Small Employer is eligible for the health care coverage provided under this Group Plan by virtue of being a Small Employer as defined in the Florida Statutes at the time this Group Plan is issued. The Small Employer shall offer to all eligible employees the opportunity to become a Covered Employee under this Group Plan. Such offer shall be made in such a fashion that employees are made aware, and understand, that this Group Plan contains a benefit structure that encourages the use of a Primary Care Physician.

RESPONSIBILITIES OF THE HEALTH PLAN
In consideration of the payment of Premium by the Small Employer, the Health Plan shall provide coverage for Covered Employees and their Covered Dependents. In doing so, the Health Plan may enter into agreements with providers of health care and such other individuals and entities as may be necessary to enable the Health Plan to fulfill its obligations under this Group Plan.

The Health Plan agrees to provide coverage without discrimination on the basis of race, color, sex, religion, national origin or any other basis prohibited by law.

EMPLOYEE ELIGIBILITY
An employee becomes eligible for coverage on the date he or she completes the waiting period, if any, as established by the Small Employer. The waiting period is the length of time an employee must wait before becoming eligible for coverage. The waiting period may not exceed ninety (90) days and is designated by the Small Employer and shown on the Group Plan Information Page.

If an eligible person is covered under any other Group Plan issued to the Small Employer by the Health Plan, they will not be considered eligible for coverage under this Group Plan. For example, if the Small Employer offers both a HMO and a POS benefit plan, the eligible employee may only be covered under one (1) of the two (2) options offered by the Small Employer.

COMMENCEMENT OF COVERAGE
On the Group Plan Effective Date as shown on the Group Plan Information Page, the Health Plan agrees to provide the coverage stipulated in this Group Plan to all Covered Employees and their Covered Dependents, if any. Such coverage begins on the Covered Person's effective date (See Special Enrollment and Effective Dates provisions). The Health Plan accepts no liability for expenses incurred prior to the Covered Person's effective date or after the Covered Person's termination date, except as described in the Extension of Benefits provision. The term of Coverage shall be no less than for a period of twelve (12) months unless otherwise requested by the Small Employer in writing.

TERMINATION OF THIS GROUP PLAN BY THE SMALL EMPLOYER
The Small Employer may terminate this Group Plan as of any Premium due date and should give the Health Plan at least forty-five (45) days prior written notice. In such event, no benefits will be provided on or after such termination date, except as specifically set forth in this Group Plan.

TERMINATION OF THIS GROUP PLAN BY HEALTH FIRST HEALTH PLANS

The Health Plan may terminate this Group Plan as of any Premium due date if the Small Employer has not paid the required Premium by the end of the grace period, as defined in the Grace Period provision. However, if the Small Employer has given the Health Plan prior written notice of an earlier date of termination, this Group Plan will terminate as of that earlier date. The Small Employer is liable to the Health Plan for any unpaid Premium for the time the Group Plan was in force or for any amounts otherwise due to the Health Plan.

If the Group's coverage is terminated for non-payment of premium as set forth in this Group Plan, the Health Plan will mail the Employer a written notification that this Group Plan has terminated within five (5) business days of the date of termination. This notification will state the date of termination and the reason(s) for termination. It is the Employer's obligation to immediately notify each Covered Person of any such termination.

The Health Plan may also terminate the group's coverage for failure to meet the following requirements as listed below with forty-five (45) days prior written notice of the intent to do so:

1. Minimum Contribution Requirements
2. Minimum Participation Requirements

The Health Plan may rescind and void this Group Plan in its entirety for intentional misrepresentation of a material fact or fraud. A rescission withdraws this Group Plan and means that no benefits will be paid for any claims submitted whether or not such claim relates to the condition about which material information was intentionally misrepresented or omitted. The Health Plan may choose either to refund the rescinded Group's Premiums after the deduction of any
claims or payments made under this Group Plan or may reverse any claims paid and refund the full Premium amount paid.

TERMS OF RENEWAL

This Group Plan is a guaranteed renewable Plan. This means the Plan renews each year on the Group Plan Anniversary Date shown on the Group Plan Information Page. The Health Plan guarantees the Small Employer the right to renew the Group Plan each year, at the Small Employer's option. With the exception of non-payment of Premium or loss of eligibility, the Health Plan will give the Group at least forty-five (45) days advance written notice of the Health Plan's intent to non-renew this Group Plan, if one of the following circumstances has occurred:

1. The Small Employer fails to comply with material provisions of this Group Plan which relates to rules for contribution or participation;
2. The Small Employer and/or enrollees no longer work or reside in the service area of the Health Plan or in the area in which the Health Plan is authorized to do business;
3. The Small Employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Group Plan;
4. If applicable, the Small Employer no longer belongs to a bona fide association under which this Group Plan was obtained.

Bona fide association is defined as an association that has been actively in existence for at least five (5) years, has been formed and maintained for purposes other than obtaining insurance, does not condition Membership on any health-status-related factor, makes health insurance coverage available to all Members regardless of any health-status-related factor and does not make health insurance coverage available other than in connection with a Membership in the association.

DISCONTINUANCE OF THE GROUP PLAN

The Health Plan may discontinue offering this particular Group Plan form if:

1. The Health Plan provides at least ninety (90) days notice to each policyholder and to participants and beneficiaries covered under the Plan prior to renewal; and
2. The Health Plan offers each policyholder the option to purchase all other coverage currently being offered by the Health Plan.

DISCONTINUANCE OF ALL COVERAGE IN THE SMALL GROUP MARKET

The Health Plan may discontinue offering all coverage in Florida if:

1. The Health Plan provides notice to the Department of Financial Services, Office of Insurance Regulation and each Small Employer and enrollee 180 days prior to renewal; and
2. All Small Group health coverage issued or delivered for issuance in Florida is discontinued and coverage under such plans is not renewed.

PREMIUM PROVISIONS

PAYMENT OF PREMIUM / PREMIUM DUE DATE

The first Premium payment is due upon application. Each following Premium payment is due the first day of each month. Premium payments should be sent to the Health Plan's home office or the billing address provided by the Health Plan. If less than 90% of the monthly premium is received, HFHP reserves the right to pend all claims until payment is made in full.

THE GRACE PERIOD

This Group Plan has a 10-day grace period. A grace period means that if any required Premium is not paid on or before the date it is due, it may be paid during the grace period immediately following that Premium due date. During the grace period, the Group Plan will stay in force. If the Premium is not paid by the end of the grace period, the Group's Plan coverage will terminate back to the last day of the month for which the Premiums were paid in full.

The Small Employer may apply for reinstatement by remitting all due and past-due premiums to the Health Plan along with a written request for reinstatement within five (5) business days of the receipt of the termination notice. The Health Plan may, at its discretion, agree to reinstate this Group Plan. The Small Employer will be notified in writing if the reinstatement request is approved or denied. If the Group Plan is reinstated, the effect shall be as if the Group Plan had not terminated. If the reinstatement request is denied, all premiums remitted past the termination date will be refunded to the Small Employer. Premiums remitted and processed do not guarantee reinstatement.

MONTHLY PREMIUM STATEMENT

The Health Plan will prepare a monthly statement of the Premium due on or before the Premium due date. This monthly statement will also reflect any pro rata Premium charges and credits resulting from changes in the number of Covered Persons and changes in the Coverage Type that took place in the previous month. If a Covered Person becomes ineligible for coverage under this Group Plan for any reason, the Small Employer shall, if possible, provide the Health Plan with prior written notice of such ineligibility. However, in any event, the Small Employer shall provide written notice of such ineligibility to the Health Plan no later than thirty-one (31) days after such ineligibility. In the event that notice of termination of a Covered Person, or a decrease in coverage, is received timely by the Health Plan, retroactive credit shall be provided for any premium paid after the date of termination or decrease in coverage.

The Small Employer is obligated to submit payment for premium on a monthly basis by the premium due date regardless of whether or not the monthly premium statement is received by the Small Employer.

SIMPLIFIED ACCOUNTING

To simplify the accounting process, Premium adjustments will appear on the monthly Premium statement following the date:

1. A person becomes covered;
2. The Coverage Type for a Covered Person changes, e.g., coverage changes from Employee Only to Employee + Family; or
3. A person ceases to be covered.

Maximum retroactive adjustment of thirty-one (31) days is allowed, so it is important for the Small Employer to notify the Health Plan of any terminations in a timely fashion.

In determining such adjustments, the parties agree that a monthly premium payment shall be made for any person who is enrolled as a Covered Person as of the fifteenth (15th) day of a month, and that no monthly premium is required for any person who first enrolls as a Member on the sixteenth (16th) day of the month or later. For terminations, coverage for a Covered Person will end on the last day of the month in which the Covered Person loses eligibility and the full monthly premium is due to the Health Plan.

MONTHLY PREMIUM RATES

The monthly Premium rate for each Covered Employee is shown on the Group Plan Information Page.

CHANGES IN PREMIUM

No change in Premium rates will be made for the first twelve (12) months that this Group Plan is in effect. A change in Premium rates will not be made more often than once in a twelve (12) month period. The Health Plan will give the Small Employer written notice of any changes in premium rates at least forty-five (45) days prior to the Group's renewal date.

INCORRECT PREMIUM PAYMENT

Any Premium adjustment made due to the correction of an error in the Premium payments will be made without interest on the next Premium due date after the facts are made known and acceptable to the Health Plan. The Health Plan may terminate coverage for non-payment of premium if payment is less than the amount due after credits and debits have been made for recognized enrollment adjustments.

HEALTHY LIFESTYLE REBATE PROGRAM

The Healthy Lifestyle Rebate program offers Small Groups the opportunity to receive a maximum potential premium rebate of ten percent (10%) if specific lifestyle indicators are maintained or improved as outlined. The lifestyle indicators tracked in this program are body mass index (BMI) determined by a Subscriber's height and weight, and smoking status.

In order to participate in the rebate program, employees enrolled on the Group's initial effective date will need to consult with a network Primary Care Physician (PCP) to document their height, weight and smoking status. This consultation is required to occur within the first ninety (90) days of initial enrollment and any cost share associated with this visit will be waived. Employees completing the assessment during the required time frame are referred to as Program Participants. At least fifty-one (51%) of the enrolled employees must become Program Participants in order for the Employer to be eligible to continue participation in the rebate

program. Program Participants still actively employed and insured thirty (30) days prior to the Group's first anniversary date, will be required to submit to an additional PCP consultation (cost share is waived) where height, weight and smoking status will be re-documented prior to the Group's Anniversary Date. The network PCP's will then forward this data to the Health Plan for evaluation against the criteria outlined below.

Program Participants will be stratified into the following six (6) risk categories:

Initial Status	**Opportunity/Outcome**	**Points Earned**
Not Obese, Non-Tobacco User	Maintains Status	0.5
Not Obese, Tobacco User	Switches to Non-Tobacco User	1.0
Obese, Non-Tobacco User	Switches to Not Obese	1.0
Obese, Tobacco User	Switches to Not Obese	1.0
Obese, Tobacco User	Switches to Non-Tobacco User	1.0
Obese, Tobacco User	Switches to Not Obese and Non-Tobacco User	2.0
Morbidly Obese, Non-Tobacco User	Switches to Obese or better	1.0
Morbidly Obese, Tobacco User	Switches to Obese or better	1.0
Morbidly Obese, Tobacco User	Switches to Non-Tobacco User	1.0
Morbidly Obese, Tobacco User	Switches to Obese or better and Non-Tobacco User	2.0

Not Obese, Obese and Morbidly Obese will be defined utilizing generally accepted medical standards as referenced and published by the National Institutes of Health. Accordingly Program Participants with a BMI of less than thirty (30) will be categorized as Not Obese, those with a BMI between thirty (30) and forty (40) will be categorized as Obese, and those with BMI's over forty (40) will be categorized as Morbidly Obese.

Tobacco user is defined as the use of tobacco product or products on average four or more times per week within the past six (6) months by legal users of tobacco products (18 years and older) and includes all tobacco products.

Program Participants meeting the indicated Opportunity/Outcome results listed in the table will be credited with points as outlined. Those failing to meet the Opportunity/Outcome results will not receive any credit. The Health Plan will then total the points earned for each Program Participant completing both consultations. These points will be divided by the average number of employees enrolled in the Group's plan during the Calendar Year.

Example: ABC Company
Initial effective date – Ten (10) employees enrolled in the group's health plan
Ninety (90) Days from effective date – Eight (8) employees submit to network PCP consultations
Average Number of Employees Enrolled in the group's health plan during the Calendar Year = Ten (10)

Thirty (30) Days Prior to Group Anniversary Date:
Six (6) of the original eight (8) are still enrolled in the group's health plan
Four (4) of the six (6) submit to re-documentation and earn one (1) point each
Group credited with four (4) points
Four (4) points divided by ten (10) (Average EE Enrollment) = .40%
Group earns four percent (4%) premium rebate (.40*10%)

The Health Plan will issue a rebate check to the Employer within sixty (60) days of the Group's Anniversary Date or their termination date if earlier so long as all program requirements outlined above have been met. The rebate amount is the calculated premium rebate multiplied by the Group's calendar year earned premium. If the Group renews and wishes to continue participation in the program fifty one (51%) of employees effective upon the anniversary date will need to submit to initial PCP consultations. Ongoing Program Participants will only be required to submit to one (1) annual re-certification versus the two (2) certifications required for initial Program Participants. All other terms outlined herein will apply in subsequent years.

Employees hired during the plan year are eligible to participate in the program only upon the Group's anniversary date for the following plan year.

FITNESS CENTER MEMBERSHIPS

Fitness center membership is Covered to assist the Insured with maintaining or improving their health status. The Health Plan offers a fitness center membership to the Insured exclusively at fitness centers contracted as Participating Providers. A Physician release may be required prior to accessing this benefit and continued eligibility for this program is subject to separate rules of conduct as established by the Participating Facilities. Membership to Pro Health and Fitness Centers is offered to members twelve (12) years of age and older. Age limitations may apply for other Participating fitness centers as well.

GENERAL GROUP PLAN PROVISIONS

ENTIRE GROUP PLAN
The entire agreement is made up of this Group Plan, the Small Employer Group Application, and the enrollment forms of all Covered Employees. All statements made by the Small Employer or by a Covered Employee are considered to be representations, not warranties. This means that the Health Plan will consider the statements made by the Small Employer or the Covered Employees to have been made in good faith. No such statement will void this Group Plan, reduce the benefits it provides, or be used in defense to a claim for coverage unless it is contained in a written application and a copy is furnished to the person making such statement.

Time Limit for Certain Defenses
After two (2) years from the effective date of this Group Plan, no misstatement made by the Small Employer, except a fraudulent misstatement made in the Small Employer's application, may be used to void this Group Plan.
After two (2) years from a Covered Person's effective date, no misstatement made by the Covered Person, except a fraudulent misstatement on his or her application, may be used to void coverage back to the effective date or deny a claim for any benefit that begins after the end of the two (2) year period from the Covered Person's effective date.

THE SMALL EMPLOYER AS HEALTH FIRST HEALTH PLAN'S AGENT FOR LIMITED PURPOSES
The Small Employer is considered to be an agent of the Health Plan only for the following purposes:

1. Collecting employee enrollment information; and
2. Collecting any required employee contribution; and
3. Distributing Certificates of Coverage or other coverage information to the Covered Employees.

In all other respects, the relationship between the Small Employer and the Health Plan is solely that of independent contractors.

ADMINISTRATION
The Small Employer must provide the Health Plan with the information necessary to administer this Group Plan and to compute the Premium due. Failure of the Small Employer to provide this information will not void or continue a Covered Person's coverage. the Health Plan has the right to examine the Small Employer's records on any issues necessary for the proper administration of this Group Plan at any reasonable time while this Group Plan is in force.

COBRA ADMINISTRATIVE SERVICES PROVISIONS
The Health Plan may designate a person or entity to be the COBRA Administrator for designated COBRA administrative functions of the Small Employer only if accepted by the Small Employer. The COBRA Administrator will assume responsibility for administering certain aspects of COBRA as the agent, for and on behalf of such Small Employer. The COBRA Administrator is not an agent or apparent agent of the Health Plan. The Health Plan is not the plan administrator or plan sponsor for the purposes of COBRA and has no responsibility for the Small Employer's administration obligations except for the designation of a COBRA Administrator. Any Small Employer electing services of the COBRA Administrator agrees to indemnify and hold harmless the Health Plan, their directors, officers, employees and agents against any and all claims, lawsuits, settlement, judgments, costs, taxes and expenses including reasonable attorney's fees directly resulting from or arising out of the Small Employer's failure to perform COBRA administration responsibilities not delegated to the COBRA Administrator. In addition, the Health Plan shall not be liable for any claims of Covered Persons after his/her termination of coverage.

FINANCIAL RESPONSIBILITIES OF THE SMALL EMPLOYER
The Health Plan reserves the right to recover any benefit payments made to or on behalf of any individual whose coverage has been terminated. Recovery efforts will relate to benefit payments made for services or supplies rendered subsequent to the Covered Person's termination date and prior to the date notice of coverage termination by the Small Employer is received. The Small Employer shall cooperate with and support such recovery efforts.

In the event that the Small Employer does not comply with the notice requirements set forth in the Premium Statement section, the Small Employer shall be solely liable, to the extent of any payment made on behalf of such individual for services or supplies rendered subsequent to the date notice of a Covered Person's termination was due.

CERTIFICATES OF COVERAGE
The Health Plan will issue Certificates of Coverage for each Covered Employee. The Certificate will describe the benefits provided and the limitations of this Group Plan.

The Employer agrees to distribute to Covered Persons, the Certificate of Coverage and any amendments or endorsements to it, and any other coverage materials and notices applicable to all or any Covered Persons. The Health Plan will also send the Covered Person a Certificate of Coverage along with their Plan ID card.

CHANGES TO THIS GROUP PLAN
The Health Plan may change this Group Plan without notice from time to time as required by applicable state and federal laws and subject to Florida Department of Financial Services, Office of Insurance Regulation approval. No change to this Group Plan will be effective unless made by an amendment or rider that has been signed by an officer of the Health Plan. No agent or broker may change this Group Plan or waive any of its provisions.

If the Health Plan increases the cost share for any benefit or deletes, amends, or limits any of the benefits to which a Covered Person is entitled to under this plan, written notice will be provided to the Group forty-five (45) days prior to renewal. The Group will not be notified if benefits are increased or if the Group requests any changes, deletions or limitations.

WORKERS' COMPENSATION
This Group Plan does not affect or take the place of Worker's Compensation unless exempt from coverage under Florida law.

CERTIFICATE PROVISIONS MADE A PART OF THE GROUP PLAN
The remainder of the Group Plan consists of the provisions shown in the certificate issued to Covered Employees under this Group Plan. These provisions are made a part of the Group Plan. Amendments, if any, changing the provisions of the certificate, are also made a part of the Group Plan.

SERVICE AREA
The Service Area consists of all the zip codes in Brevard and Indian River Counties.

HEALTH FIRST HEALTH PLANS, INC.
6450 US Highway 1
Rockledge, Florida 32955

CERTIFICATE OF POS COVERAGE

Please call (855) 443-4735 for assistance regarding claims and information about coverage.

Employer Name: **Brevard Workforce**

Group Plan Number: **114168**

Group Plan Design: **SG Value Choice POS Option VC1**
Rx $2/15/30/50/20%

Customer Service Number: **(855) 443-4735**

In accordance with the terms of the Group Plan issued to the Small Employer, Health First Health Plans, (hereinafter called the Health Plan), certifies that it will cover all eligible enrolled persons for the services described in this certificate. This certificate replaces any and all certificates and riders previously issued.

The Health Plan will provide the services described in this certificate to covered employees and their covered dependents, if any, on a direct-service basis. This means that the Health Plan arranges or contracts with physicians, hospitals, or other providers of medical care and employs administrative personnel to directly provide, organize, and arrange for such service. The Health Plan agrees to use its best efforts to assure that its providers render quality health care services in conformity with accepted community medical standards. The physicians, hospitals and providers of medical care are not the Health Plan's agents, apparent agents or employees, nor is the Health Plan their agent, apparent agent or employee. Nothing contained in this Group Plan is intended to interfere with communication between Covered Employees and their physicians, hospitals, and providers, and the Health Plan does not control the clinical judgment or treatment recommendation made by any provider.

This certificate describes the administrative details, services, provisions, and limitations of the group plan. The services outlined in this certificate are effective only if a person is eligible for coverage, becomes covered, and remains covered in accordance with the terms of this plan.

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

President, CEO
Health First Health Plans, Inc.

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The provisions of this certificate are divided into two sections. The Administrative Provisions section explains who is eligible, when coverage becomes effective, when coverage ends, what options are available when coverage ends, and other details on how the plan works. The Coverage Provision sections explain how benefits should be obtained, what is covered and what is not covered and definitions of common terms used in this Group Plan.

1.0 ADMINISTRATIVE PROVISIONS

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

1. Who is eligible for benefits under this Group Plan, when coverage becomes effective, when coverage terminates and what the Covered Person can do to continue coverage upon termination;
2. How this Group Plan will relate to other plans under which Covered Persons have coverage or other situations where payment is made for the services covered under this Group Plan; and
3. How the Covered Person can appeal to the Health Plan upon disagreement of coverage based decisions.

1.1 ELIGIBILITY AND EFFECTIVE DATES

Because this coverage is group coverage, eligibility for coverage is tied to the individual's relationship with the Employer that establishes this Group Plan. The following sections explain the eligibility and effective dates of this coverage.

1.1.1 ELIGIBILITY UNDER THIS GROUP PLAN

To be eligible for coverage under this Group Plan, an individual must be either:

1. An Eligible Employee of the Employer. An **Eligible Employee** means an individual who works for and receives compensation from the Employer on a full time basis, with a normal workweek of twenty-five (25) or more hours and requires that the employee lives or works in the service area (unless enrolled in a POS plan).
2. An Eligible Dependent of an Eligible Employee who resides in the Service Area (unless enrolled in a POS plan).
    a. An Eligible Employee's spouse under a legally valid existing marriage
    b. An Eligible Employee's child until the end of the Calendar Year in which the child reaches age twenty-six (26).
3. Unmarried children without dependents of their own may continue coverage from the end of the Calendar Year in which they turn age 26 until the end of the Calendar Year in which they reach age thirty (30), if the child meets the following requirements:
    a. The child is a Florida resident or a full or part-time student;
    b. The child is not provided coverage under any other group, blanket, franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.
4. The Newborn child of a Covered Dependent child. Coverage for such Newborn child will automatically terminate eighteen (18) months after the birth of the Newborn child. The Health Plan must be notified of a Newborn add-on within sixty (60) days of birth. If notice is given within sixty (60) days of the birth of a child then the Health Plan will not deny Coverage.

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

The Health Plan reserves the right to periodically audit of dependent eligibility status.

The term **child** includes the employee's natural born child, stepchild, foster child or legally adopted child of the employee upon placement in the employee's residence, or at the birth of a

newborn adopted child, where a written agreement to adopt such child has been entered into prior to the birth of the child. If the foster or adopted child is ultimately not placed in the residence of the employee, no benefit will apply.

The term also includes any child for whom the employee is the court appointed legal guardian, a child who is dependent on the employee for health care coverage pursuant to a Qualified Medical Child Support Order (QMCSO), or any child who lives with the employee in a normal parent-child relationship, if the child qualifies at all times for the dependent exemption, as defined in the Internal Revenue Code and the Federal Tax Regulations. The Health Plan has the right to request proof of the child's dependency status at any time.

1.1.2 ENROLLMENT TIMEFRAMES

There are four time periods during which an eligible Employee or Dependent can enroll for coverage under this Group Plan:

1. The **Initial Enrollment Period** is the period of time during which an employee or dependent is first eligible to enroll. It begins on an employee or dependent's initial date of eligibility and ends thirty-one (31) days later.
2. The **Open Enrollment Period** is an annual period beginning thirty (30) or thirty-one (31) days prior to the anniversary date of the employer's program, during which:
    a. If the Employer offers more than one health plan option through the Health Plan, an employee may change to one of the alternatives offered.
    b. Employees who decided not to enroll for coverage under the Health Plan during the Initial Enrollment Period may now enroll themselves and their Eligible Dependents.
3. A **Special Enrollment Period** of thirty-one (31) days is provided for special circumstances described in the Special Enrollment Provisions section.
4. Within sixty (60) days of losing eligibility for Medicaid or a Children's Health Insurance Program (CHIP) or if they become eligible for premium assistance under Medicaid or CHIP.

1.1.3 ENROLLMENT PROCEDURES

Eligible Employees and eligible dependents that become covered under the Health Plan will be referred to as "Covered Persons". To become a Covered Person, the employee must:

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

Eligible Employees and Dependents who do not enroll within the Initial Enrollment Period must wait until the next Open Enrollment Period to enroll unless they qualify earlier due to circumstances provided for under Special Enrollment Provisions.

1.1.4 EFFECTIVE DATES

The effective date of a Covered Person under the Health Plan depends upon when they enroll:

1. If the Covered Person is eligible for coverage on the Group Plan effective date, coverage will be effective on the Group Plan effective date.
2. If the Covered Person becomes eligible after the Group Plan effective date and enrolls during the Initial Enrollment Period, coverage will be effective on the date the employee

becomes eligible. This includes those new employees required to fulfill an employer waiting period. (See Waiting Period in the Definitions section.)

3. If the Covered Person qualifies and enrolls as a Special Enrollee, coverage will become effective on the date of the qualifying event, i.e., marriage, birth, termination of other group coverage, etc. If the Covered Person qualifies and enrolls as a full-time student, coverage will become effective on the date classes begin for the specified term.
4. If the Covered Person enrolls during the Open Enrollment Period, coverage will become effective on the anniversary date.

1.1.5 COVERAGE FOR NEWBORN CHILDREN

All health coverage applicable for children under this Group Plan will be provided for the newborn child of the Covered Employee or to a Covered Dependent from the moment of birth if the Covered Employee has dependent coverage and enrolls the newborn timely. However, with respect to the newborn child of a Covered Dependent of the Covered Employee other than the Covered Employee's spouse, the coverage for a newborn child terminates eighteen (18) months after the newborn's birth as long as the covered dependent remains an eligible enrolled dependent of the Covered Employee.

Newborn coverage shall take effect at the moment of birth provided the Health Plan is notified by the Covered Person to enroll the child within sixty (60) days of the newborn's date of birth. If the Covered Person enrolls the newborn within thirty-one (31) days of the birth, no Premium will be charged for the first thirty-one (31) days. If the Covered Person fails to enroll the child within thirty-one (31) days of birth, but enrolls the child within sixty (60) days of birth, the Covered Person will be required to pay Premium from the date of birth. If notice of the birth is not given within sixty (60) days of birth, the newborn child will be considered a Late Enrollee and ineligible to enroll for coverage until the next Annual Open Enrollment Period.

1.1.6 COVERAGE FOR HANDICAPPED CHILDREN

If a child attains the limiting age for a Covered Dependent (see section titled Eligibility Under this Group Plan), coverage will not terminate while that person is, and continues to be, both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly dependent on the Covered Employee for support and maintenance.

If a claim is denied for the stated reason that the child has reached the limiting age for dependent coverage, the Covered Employee has the burden of establishing that the child is and continues to be handicapped as defined above.

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

1.1.7 SPECIAL COVERAGE FOR MEDICARE PRIMARY BENEFICIARIES

This coverage is not available to employers for whom Medicare is a Secondary Payer. Medicare Secondary Payer rules are defined in the Social Security Act in Section 1862(b) and are applicable to employers that employ 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

For those employers where Medicare is Primary, the Health Plan will provide the employer the opportunity to offer a Group Medicare Advantage Plan alongside the employer sponsored health plan. If the employer chooses to implement this alternate offering, Medicare eligible employee(s) and/or their dependent spouse(s) (if applicable) may voluntarily elect to be covered by the Group Medicare Advantage plan then being offered. Upon election the participants will be enrolled in the Group Medicare Advantage Plan and terminated from the small employer's health plan. Final acceptance into the Group Medicare Advantage Plan is subject to the Center for Medicare and Medicaid Services (CMS) approval. Accepted participants will receive an Evidence of Coverage outlining the Group Medicare Advantage Plan's coverage and exclusions and limitations per CMS guidelines.

Group Medicare Advantage Program

The Health Plan currently offers a Group Medicare Advantage Program that includes comprehensive coverage including Part D prescription drug coverage. This plan is offered annually under a separate contract with the CMS. As such, benefits and premiums for the Group Medicare Advantage Plan are adjusted each calendar year, which may or may not coordinate with the small employer's anniversary date. Affected small employers and their Group Medicare Advantage enrollees will be provided with the new calendar year benefits and premiums in the Annual Notice of Change (ANOC) in accordance with CMS guidelines.

Enrollment

Medicare eligible employee(s) and their dependent spouse(s), if applicable, may enroll into the Group Medicare Advantage Plan during the following time frames:

1. When the small employer first elects coverage with the Health Plan. Coverage becomes effective on the same date as the Group policy.
2. During the employee's initial Medicare eligibility window, beginning 90 days prior to turning 65 and ending 90 days after turning 65. Coverage would become effective the first of the month in which the employee turns 65.
3. During Medicare's open enrollment season which runs from [November 15 to December 31st] each calendar year. Coverage would become effective the following January 1st.

Ability to switch back to the small employer health plan

Group Medicare Advantage participants may switch back to the small employer health plan:

1. As a result of changes outlined in the ANOC to become effective on the following January 1st. Coverage in the Group Medicare Advantage plan would terminate December 31st and the small employer health plan's coverage would resume January 1st with no lapse in coverage.
2. During the small employer health plan's open enrollment. Participants are able to opt back into the small employer health plan and become effective on the anniversary date without any lapse in coverage.
3. Should the Health Plan discontinue participation in the federal Medicare Advantage Program, the covered participants would have the ability to opt back into the small employer's health plan. Coverage would become effective January 1st.

Billing

The small employer will be billed the Group Medicare Advantage premium for any Medicare eligible employees and spouses that choose to participate in the plan. It is expected that the small employer will pay a minimum of 50% of the employee's monthly premium liability. If the spouse of a Medicare eligible employee is not yet Medicare eligible, the spouse and dependents

(if any) may remain on the small employer's health plan as dependent(s) only and will be charged a rate to be calculated as prescribed in FAC 9690-149.037, .038 for continuation rates.

1.1.8 SPECIAL ENROLLMENT PERIOD

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

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

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

When coverage is requested within thirty-one (31) days of the "qualifying event" or termination of other employer sponsored coverage, enrollment will be allowed outside of the Initial Enrollment and Open Enrollment Periods, with coverage becoming effective on the date of the qualifying event or retroactively to the date coverage terminated.

1.2 TERMINATION OF GROUP COVERAGE

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

1.2.1 TERMINATION OF COVERAGE

A Covered Person's coverage under this Group Plan will end automatically at 11:59 pm, Eastern Standard Time, on the date:

1. The Covered Person's coverage is terminated for cause (See the *Termination of Individual Coverage* provision below);

A Covered Person's coverage under this Group Plan will end automatically at 11:59 pm, Eastern Standard Time, at the end of the month in which:

1. The contract between the Small Employer and the Health Plan terminates; or
2. The Covered Person no longer meets eligibility requirements or;
3. The Covered Person becomes covered under an alternative health benefits plan which is offered through or in connection with the Small Employer.

The Covered Employee must notify the Health Plan as soon as possible when a Covered Dependent is no longer eligible for membership. If a Covered Dependent fails to continue to meet each of the Health Plan's eligibility requirements, and such proper notification is not timely provided by the Covered Person to the Health Plan, then the Health Plan shall have the right to retroactively terminate Membership of such Dependent to the date any such eligibility

requirement was not met, and to recover an amount equal to the Allowance for services and/or supplies provided following such date less any premiums received by the Health Plan for such Covered Dependent for coverage after such date.

If the Small Employer offers an alternative health benefit plan for Medicare eligibles or retirees, and an individual elects to be covered under such a plan, then such individual shall not be eligible for Membership.

1.2.2 TERMINATION OF AN INDIVIDUAL'S COVERAGE FOR CAUSE

A. Unless otherwise prohibited by law, if in the Health Plan's opinion any of the following events occur, a Covered Person's coverage may be terminated:
   1. The date specified by the Health Plan due to the Covered Person's disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that such Covered Person's continued Coverage in the Health Plan impairs the Health Plan's ability to provide coverage and/or arrange for the delivery of health care services to Covered Persons. Prior to disenrolling a Covered Person for any of the above reasons, the Health Plan will:
      a. make a reasonable effort to resolve the problem presented by the Covered Person, including the use or attempted use of the Health Plan's Grievance Procedure; and
      b. to the extent possible, ascertain that the Covered Person's behavior is not related to the use of medical services or mental illness; and
      c. document the problems encountered, efforts made to resolve the problems, and any of the Covered Person's medical conditions involved.
   2. The date specified by the Health Plan that all coverage will terminate due to: (a) fraud or intentional misrepresentation of a material fact in applying for or presenting any claim for benefits under this Group Plan; or (b) permitting the use of their Plan ID Card by non-covered persons; or (c) furnishing of false or incomplete information on the enrollment application for the purpose of fraudulently obtaining benefits. False, material information includes, but is not limited to information relating to residence or another person's eligibility for coverage or status as a Dependent. If such activity does occur, the Health Plan reserves the rights to recoup any funds paid out under false pretenses and/or rescind the policy in its entirety.
   3. The date specified by the Health Plan if the Covered Person leaves the Health Plan's Service Area and no longer meets the eligibility requirements as stated under section 1.1.1

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

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

1.2.3 CERTIFICATE OF CREDITABLE COVERAGE

Within thirty-one (31) days of a Covered Person's last date of coverage under the Health Plan, a Certificate of Creditable Coverage will be produced and mailed to the Covered Person's last known address on file. This Certificate will indicate who was covered under the Health Plan and the period of time the Covered Person was enrolled under the Health Plan. The Certificate of Creditable Coverage provides evidence of a Covered Person's coverage that may be needed when applying for future health coverage. To request a Certificate of Creditable Coverage while your coverage is still in force please contact our Customer Service Department at (855) 443-4735 for assistance. **1.3 RIGHTS TO CONTINUE COVERAGE**

1.3.1 EXTENSION OF BENEFITS
In the event this Group Plan is terminated in its entirety and a Covered Person is totally disabled on the date the Group Plan is terminated, the benefits described in the Covered Services section will be payable, subject to the regular benefit limits described in the Covered Services section, for expenses incurred due to the sickness or injury which caused such continuous total disability. This extension of benefits will cease on the earliest of:

1. The date on which the continuous total disability ceases; or
2. The end of the twelve (12) month period immediately following the termination date of the Group Plan; or
3. The group secures replacement coverage from another health care benefit plan that covers the sickness or injury causing the total disability.

For pregnancy, services directly related to the pregnancy will continue until the pregnancy ends, provided the pregnancy began after the Covered Person's effective date and prior to the termination of the Group Plan. This extension will not be based on total disability.

For the purposes of this section, "continuous total disability" and "totally disabled" mean:

1. For the Covered Employee, the inability to perform any work or occupation for which the Covered Employee is reasonably qualified for or trained.
2. For any other Covered Person, the inability to engage in most normal activities of a person of like age and sex in good health.

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

1. For cause, due to disruptive, unruly, abusive, or uncooperative behavior to the extent that such Covered Person’s continued Coverage in the Group Plan impairs the Health Plan’s ability to administer this Plan or to arrange for the delivery of health care services to such Covered Persons;
2. For fraud or intentional misrepresentation or omission in applying for any benefits under this Group Plan;
3. For failure of the Small Employer to pay the required premium;
4. For leaving the Health Plan’s Service Area with the intent to relocate or establish a new permanent residence.

1.3.2 FEDERAL CONTINUATION OF COVERAGE PROVISIONS (For employers with 20 or more employees)
Rights to continuation of coverage under the federal law, Consolidated Omnibus Budget Reconciliation Act (COBRA) is applicable to Covered Persons upon termination as described herein.

In order to be eligible for continuation coverage under this federal law, the definition of a “Qualified Beneficiary” must be met.

Types of Qualifying Events

1. Termination of employment for any reason other than gross misconduct; or
2. Reduction in a Covered Employee’s hours of employment; or
3. Death of the Covered Employee; or
4. Divorce or legal separation from the Covered Employee; or
5. Ceasing to be an eligible dependent under the terms of the Group Plan; or

6. The Covered Employee's entitlement to Medicare; and
7. Employer bankruptcy.

Qualified Beneficiaries

Every qualified beneficiary must be offered the opportunity to elect COBRA during the election period. To be a qualified beneficiary, a person must generally satisfy two conditions:

1. the person must be a covered employee, the spouse of a covered employee or the dependent child of a covered employee; and
2. the person must be covered by a group Health Plan immediately before the qualifying event.

A qualified beneficiary who has other group health plan coverage or who is entitled to Medicare at the time of a COBRA election is entitled to elect COBRA and may choose to have dual coverage for the entire COBRA coverage period.

Type of COBRA Coverage Offered

COBRA coverage must be identical to the coverage provided to similarly situated beneficiaries under the Health Plan under which a qualified beneficiary was covered immediately prior to the qualifying event. However, if the Employer Group offers a POS plan, a qualified beneficiary may elect COBRA coverage with the POS plan if the qualified beneficiary permanently relocates outside the service area of the Health Plan. Qualified beneficiaries who are offered HMO coverage only by their employer are not eligible to continue coverage when permanently relocating outside the service area.

COBRA qualified beneficiaries may change coverage at Open Enrollment under the same considerations as active employees. A qualified beneficiary may do the following things during open enrollment under the Health Plan, if a non-COBRA beneficiary is allowed to do so:

1. change benefit options or packages within the plan under which he or she was covered prior to the qualifying event;
2. add coverage for dependents; and
3. switch to other group health plans offered by the Employer Group.

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

If the group's health coverage for active employees changes, the COBRA coverage for similarly situated qualified beneficiaries also changes accordingly.

Length of COBRA Coverage

COBRA continuation coverage generally starts on the date of the qualifying event and may last through the "maximum coverage period" depending upon the type of qualifying event.

Terminations of employment or reductions in hours have an 18-month maximum coverage period.

The death of an employee, divorce or legal separation of the employee, a child losing dependent status, or the employee becoming entitled to Medicare have a 36-month maximum coverage period.

Extension of the Maximum Coverage Period
A qualified beneficiary's maximum coverage period can be extended under the multiple qualifying events rule or the disability extension rule. COBRA does not require that a qualified beneficiary be given notice of such an extension.

Multiple Qualifying Events
The 18-month maximum coverage period for termination of employment or reduction in employment hours can be extended for multiple qualifying events, such as divorce commencing after the initial qualifying event of termination of employment. If during the 18-month coverage period the covered employee dies, the covered employee divorces or legally separates, the covered employee becomes entitled to Medicare, or the covered employee's child ceases to be a dependent, the maximum coverage period is extended to 36 months measured from the date that the 18-month period initially started.

Disability Extension
If all of the following conditions are met:

a qualified beneficiary is disabled (as determined by the Social Security Administration) on any day during the first 60 days of COBRA continuation coverage;
the qualifying event was the reason for the covered employee's termination of employment or reduction in hours; and
the qualified beneficiary notifies the Plan Administrator within 60 days after the Social Security Administration's determination of disability and before the end of the original 18-month maximum coverage period;

then the maximum coverage period for all qualified beneficiaries (including the employee) who became eligible for COBRA as a result of the same qualifying event is extended to 29 months. This is measured from the date that the 18-month period initially started.

Early Termination of COBRA Continuation Coverage
The Health Plan can terminate a qualified beneficiary's COBRA coverage, before the maximum coverage period (including any extension) expires, if any one of the following events occur:

1. the required premium for the qualified beneficiary's coverage is not paid on time (subject to COBRA grace periods); or
2. the qualified beneficiary becomes entitled to Medicare benefits after electing COBRA coverage; or
3. the qualified beneficiary becomes covered by another group health plan after electing COBRA coverage (except that if the other plan's preexisting condition exclusion or

limitation applies to a condition of the qualified beneficiary, COBRA coverage can be terminated early only after the other plan's exclusion or limitation is satisfied); or
4. the employer ceases to maintain any group health plan for any employee;
5. if the maximum coverage period has been extended under the disability extension, the qualified beneficiary who had been determined to be disabled is determined not to be disabled (COBRA coverage may be terminated for all qualified beneficiaries enjoying extended COBRA coverage under the disability extension); or
6. for cause.

Coverage During COBRA Election and Premium Payment Periods

The Health Plan will not provide COBRA coverage to a qualified beneficiary until a timely election is made and required premiums are paid. Once COBRA coverage is elected and premiums are paid, COBRA coverage will be reinstated back to the date of termination.

COBRA Election Process

The COBRA election process begins with a notice to the Plan Administrator that a qualifying event has occurred. The Employer Group has the obligation to notify the Plan Administrator when a qualified beneficiary loses or will lose coverage due to: termination or reduction in hours of a covered employee's employment, death of the covered employee, the covered employee's becoming entitled to Medicare, or the employer's bankruptcy. **The Participant or qualified beneficiary must notify the plan administrator of a qualifying event within 60 days after divorce or legal separation or a child's ceasing to be covered as a dependent under plan rules.** The Plan Administrator must be notified within 30 days of the qualifying event. The Plan Administrator then has 14 days after receiving a qualifying event notice to notify each qualified beneficiary of his or her rights under COBRA.

COBRA continuation is not automatic. A qualified beneficiary must affirmatively elect COBRA coverage within 60 days of the date the Plan Administrator provides the COBRA election notice by returning a written election to the Plan Administrator. Each qualified beneficiary has an independent right to elect COBRA coverage.

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

COBRA Premium

The COBRA premium for a month's coverage will be 102% of the applicable premium. There is an exception for coverage for a disabled qualified beneficiary during the disability extension in which the COBRA premium will be 150% of the applicable premium during the disability extension period.

Payment for the initial premium is due no later than 45 days after the qualified beneficiary elects COBRA. After that, premiums are due on the first day of each month, subject to a 30-day grace period. A premium payment is considered a shortfall and will be considered as non-payment of premium if the amount owed is greater than $50 or 10% of the outstanding COBRA premium.

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

1.3.3 STATE OF FLORIDA CONTINUATION OF COVERAGE PROVISIONS (For employers with fewer than 20 employees)

If the Group is not subject to COBRA, continuation as required by the Florida Health Insurance Coverage Continuation Act (FHICCA) may be available as described below.

If you are a Covered Person of an employer with fewer than 20 employees, you may have a right to choose this continuation coverage if one of the following Qualifying Events occurs:

1. The death of the employee;
2. The termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the employee's hours of employment;
3. Employee's divorce or legal separation;
4. The Employee becomes entitled to Medicare; or,
5. The dependent ceases to be a "dependent child" under the terms of the group health plan;
6. You also have a right to elect continuation coverage if you are covered under the plan as a retiree, spouse or child of a retiree and lose coverage within one year before or after the commencement of proceedings under Title XI (bankruptcy), United States Code by the employer from whose employment the Covered Employee retired.

Under the law, a qualified beneficiary has the responsibility to inform the Health Plan of a qualifying event. This notification must be made within thirty (30) days of the date of the qualifying event.

The notice must be in writing, and include:

1. The name of the qualified beneficiary;
2. The date of the qualifying event;
3. One of the types of qualifying events listed above;
4. The name of the employer;
5. The group health plan number;
6. The name and address of all qualified beneficiaries.

When the Health Plan is properly notified that one of these events has happened, an Election & Premium Notice will be provided by certified mail within 14 days which includes the applicable premium amount due after the election to continue coverage. Under the law, you have sixty- three (63) days from the date of receipt of the Election and Premium Notice form, to elect continuation coverage. If and when you make this election, return the Election and Premium Notice form with applicable Premium to the Health Plan within the stated time frame. Coverage will become effective the day after coverage would otherwise be terminated.

If you do not elect coverage and pay the required Premium, your group health insurance coverage will terminate in accordance with provisions outlined in this Certificate of Coverage or other applicable plan documents.

If you choose continuation coverage, your coverage will be identical to the coverage provided under the plan to active employees. The law requires that you be afforded the opportunity to

maintain continuation coverage for 18 months. However, the law also provides that your continuation coverage may be terminated for any of the following reasons:

1. The employer/former employer no longer provides group health coverage to any of its employees;
2. The employer/former employer changes insurance coverage from the Health Plan to another carrier;
3. The Premium for your continuation coverage is not paid by the expiration of the grace period, which is thirty (30) days;
4. You become, after electing continuation coverage, covered under any other group health plan (as an employee or otherwise);
5. You are approved, after electing continuation coverage, for Medicare.

*Note: A qualified beneficiary who is determined, under Title II or XVI of the Social Security Act, to have been disabled at the time of a qualifying event, may be eligible to continue coverage for an additional 11 months (29 months total) if the qualified beneficiary provides the written determination of disability from the Social Security Administration to the Health Plan within 60 days of the date of determination of disability by the Social Security Administration and prior to the end of the 18-month continuation period. The Health Plan will charge 150 percent of the group rate during the 11-month disability extension. The qualified beneficiary must notify the Health Plan within thirty (30) days upon the determination that the qualified beneficiary is no longer disabled under Title II or XVI of the Social Security Act.

You do not have to show that you are insurable to choose this coverage continuation option. However, you are required to pay 115% of the applicable premium for continuation coverage. The law also requires that, at the end of the 18-months or 29-months continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided timely enrollment is made and all other eligibility requirements are met.

Any questions regarding state continuation of coverage should be directed to the Health Plan. Also if you have changed marital status, or you, your spouse, or any eligible covered dependent have changed address, please notify the Health Plan in writing, at the address shown below:

Health First Health Plans
Customer Service
6450 US Highway 1
Rockledge, Florida 32955

If any covered child is at a different address, please notify the Health Plan in writing, so that the Health Plan may send a separate notice to the specified address.

1.3.4 THE CONVERSION PRIVILEGE

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

1. Termination of employment;
2. Termination of Covered Employee's Covered Membership in an eligible class;
3. Loss of coverage due to the termination of this Group Plan, if it is not replaced by another health care plan within 31 days of termination.

A Covered Employee's dependents that are covered as dependents under this Group Plan may also convert, but only as dependents of the Covered Employee, not on their own.

However, when a Covered Employee's dependents have been covered for 3 consecutive months before coverage ends, they may, on their own, convert to a conversion plan under one of these following conditions:

1. If the Covered Employee's conversion coverage terminates, Covered Dependents may convert under a new conversion plan.
2. If the covered spouse is no longer an Eligible Dependent as defined in this Group Plan, the spouse may convert.
3. If a Covered Dependent child is no longer an Eligible Dependent as defined in this Group Plan, such dependent may convert.

At the time of application, the eligible Covered Person will be offered a choice of at least two plans. The new coverage will be issued at rates, not to exceed 200% of the Standard Risk Rate as determined and published by the Florida Department of Financial Services, Office of Insurance Regulation.

Requesting Conversion

A Covered Person who is eligible for conversion may obtain conversion coverage without having to submit evidence of health qualification. The Covered Person must apply in writing and pay the first Premium for the conversion plan within 63 days after his or her coverage under this Group Plan terminates. The application form to be used and additional information about conversion benefits may be obtained from the Health Plan.

If the Employer qualifies for federal continuation benefits described in the Federal Continuation section, or qualifies for State Continuation as described above, conversion must not take place until the exhaustion of the federal or state continuation period.

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

1. The Covered Person has not been continuously covered for at least three months under this Group Plan and/or under another group plan providing similar benefits maintained by the employer, in effect, immediately prior to the termination of this Group Plan.; or
2. The person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or by an other plan or program; or
3. The person is eligible for similar benefits, whether or not actually provided coverage, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
4. Similar benefits are provided for or are available to the person under any state or federal law; or
5. Coverage under this Group Plan ends due to failure to pay any required Premium; or
6. This Group Plan is replaced by similar group coverage within 31 days of the termination date of this Group Plan; or
7. Federal or State Continuation coverage, if available or had been available, has not been elected or exhausted; or
8. The Covered Person has left the Health Plan’s service area with the intent to relocate or establish a new permanent residence; or
9. Failure to pay any required premium or contribution unless such nonpayment of premium was due to acts of an employer or person other than the individual.

1.4 THIS GROUP PLAN AND OTHER PAYMENT ARRANGEMENTS

1.4.1 COORDINATION OF BENEFITS

When a Covered Person is covered under this Group Plan and another health coverage plan, the Health Plan reserves the right to coordinate the benefits of this Group Plan with all applicable plans. This provision explains how that coordination will take place.

Coordination of benefits is designed to avoid the costly duplication of payment for health care services and/or supplies under multiple health coverage plans. Because of this provision, the sum of the benefits that would be payable under all plans will not exceed 100% of the total allowed expenses actually incurred.

1.4.2 PLANS AFFECTED

If any of the other health coverage plans a Covered Person has covers at least a portion of health care services or supplies covered under this Group Plan, coordination may take place. Not all health coverage plans will be considered in this coordination process. The plans that will be considered are the following:

1. Any group insurance, group-type self-insurance or HMO plan; including coverage under labor-management, trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans;
2. Any service plan contracts, group practice, individual practice, or other prepayment coverage on a group basis;
3. An insurance Contract, including an automobile insurance Contract;
4. Any coverage under governmental programs including Medicare, and any coverage required or provided by any statute.

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

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

1.4.3 ORDER OF BENEFIT DETERMINATION

If the health benefits of all of the health coverage plans the Covered Person is covered under would have exceeded the actual cost of the services or supplies rendered in the absence of this provision, this coordination process will reduce the payment by one or more of the plans to eliminate the excess payment. To determine the order in which companies will be considered and plan benefits reviewed to determine the appropriate benefit payment, the following guidelines will be used:

1. The first guideline is employee versus dependent status. The benefits of the plan that covers the person on whose expense the claim is based as an employee shall be determined before the benefits of the plan that covers the person as a dependent.
2. The second guideline is the parents' birth date. Except for cases where the dependent's parents are separated or divorced, the benefits of the parent's plan whose date of birth, excluding year of birth, occurs earlier in the Calendar Year shall be determined before the benefits of the plan of the parent whose date of birth, excluding year of birth, occurs later in a Calendar Year. (If either parent's plan does not have a similar "birthday rule" provision the criteria shall not be applied, and the rule set forth in the plan which does not have the "birthday rule" provision shall determine the order of benefits.)

3. In the case of a person for whom a claim is made as a dependent child, whose parents are separated or divorced:
    a. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of the plan that cover the child as a dependent of the parent with custody of the child will be determined before the benefits of the plan which cover the child as a dependent of the parent without custody.
    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a program which cover that child as a dependent of the parent with custody shall be determined before the benefits of a plan which cover that child as a dependent of the step-parent; and the benefits of a plan which cover that child as a dependent of a step-parent will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
    c. If there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which cover the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other program which cover the child as a dependent child.
4. When rules 1., 2. or 3. do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period shall be determined before the plan which has covered such person the shorter period of time, provided that:
    a. The benefits of the plan covering the person as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other plan covering such person as an active employee; and
    b. If either program does not have a provision regarding laid-off or retired employees, which results in each program determining its benefits after the other, then the provisions of 4.a. above shall not apply.

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

1.4.4 THIRD PARTY LIABILITY AND RIGHT OF RECOVERY

A Covered Person may receive Covered Health Services or other benefits or services in relation to an illness, a sickness, or a bodily injury incurred by the Covered Person as a result of the act or omission of an Other Party for which an Other Party may be liable or legally responsible to pay expenses, compensation and/or damages.

An Other Party is defined to include, but is not limited to, any of the following:

1. the party or parties who caused the illness, sickness or bodily injury;
2. the insurer or other indemnifier of the party or parties who caused the illness, sickness or bodily injury;
3. a guarantor of the party or parties who caused the illness, sickness or bodily injury;
4. the Covered Person's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage);
5. a Worker's Compensation insurer; or
6. any other person entity, policy, or plan that is liable or legally responsible in relation to the illness, sickness or bodily injury.

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

1. subrogate, that is, take over the Covered Person's right to receive payments from the Other Party. The Covered Person or his/her legal representative will transfer to the Health Plan any rights he/she may have to take legal action arising from the illness, sickness or bodily injury to recover any sums paid under the Group Plan on behalf of the Covered Person; and/or
2. recover from the Covered Person or his/her legal representative any benefits paid under the Group Plan on the Covered Person's behalf out of the recovery made from the Other Party (whether by lawsuit, settlement, or otherwise).

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

The Health Plan will have a first lien upon any recovery, whether by settlement, judgment, mediation, arbitration or otherwise, that the Covered Person receives or is entitled to receive from an Other Party (whether or not such recovered funds are designated as payment for medical expenses). This lien will not exceed:

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

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

If the Covered Person or his/her legal representative makes any recovery from an Other Party and fails to reimburse the Health Plan for any benefits which arise from the illness, sickness or bodily injury, then:

1. the Covered Person and his/her legal representative will be liable to the Health Plan for the amount of the benefits paid under the Group Plan;
2. the Covered Person and his/her legal representative will be liable to the Health Plan for the costs and attorneys' fees incurred by the Health Plan in collecting those amounts;
3. The Health Plan may reduce future benefits payable by the Group Plan for any illness, sickness or bodily injury up to the amount of the payment that the Covered Person or his/her legal representative has received from the Other Party; and
4. The Health Plan may terminate the Covered Person's coverage under this Group Plan.

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

For clarification, this provision for third-party liability, subrogation and right of recovery applies to the Covered Person, which is defined under the Health Plan to include eligible dependents, and to any recovery from the Other Party by or on behalf of the estate of the Covered Person.

1.4.5 RIGHT TO RECEIVE AND RELEASE INFORMATION

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

1.4.6 FACILITY OF PAYMENT

Whenever payment which should have been made by the Health Plan is made by another person, plan, or organization, the Health Plan shall have the right to pay that other person, plan or organization any amounts the Health Plan determines to be necessary under this provision. Amounts paid to another plan in this manner will be considered benefits paid under this Group Plan. The Health Plan is discharged from liability under this Group Plan to the extent of any amounts so paid.

1.4.7 RIGHT OF RECOVERY

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

1.4.8 NON-DUPLICATION OF GOVERNMENT PROGRAMS

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

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

1.4.9 MEDICARE ELIGIBLES

The Effect of Medicare Coverage/Medicare Secondary Payer
When a Covered Person becomes covered under Medicare and continues to be eligible and covered under the Group Plan, the benefits of the Group Plan shall be primary and the Medicare benefits shall be secondary as set forth below.

Working Elderly

The Small Employer shall provide the Health Plan the names of employees, age 65 or older:

a. Who are covered under this Group Plan;
b. Who are employed (not retired);
c. Who have not elected Medicare as primary payer of their health insurance claims;
d. Who are not eligible for Medicare due to the end stage renal disease (ESRD) coordination period.

;
The Small Employer shall provide the Health Plan the names of spouses, age 65 or older, of current employees of any age:

a. Who are covered under this Group Plan;
b. Who have not elected Medicare as primary payer of their health insurance claims;
c. Who are not eligible for Medicare due to the end stage renal disease (ESRD) coordination period.

The names required to be provided as set forth above, along with any other identifying information requested by the Health Plan, shall be provided on or before the 65th birthday of the employee or spouse or on or before such later date when the individual enrolls.

Individual entitlement to primary coverage under this Section will terminate automatically:

a. For a current employee, age 65 or older, when he or she elects Medicare as the primary payer or when he or she becomes eligible for Medicare due to ESRD, except during the ESRD coordination period during the first 30 months;
b. For the spouse, age 65 or older, of a current employee of any age, when the spouse elects Medicare as the primary payer or when the spouse becomes eligible for Medicare due to ESRD, except during any ESRD coordination period.
c. If the employee retires and/or no longer meets eligibility requirements.

Employers with Less Than 20 Employees
When an Employer employs less than twenty (20) employees, benefits under this Group Plan will be payable for a Covered Person who is age 65 or older and eligible for Medicare as follows:

1. If expenses are incurred for which benefits are payable by both this Group Plan and Medicare Part A, benefits are payable by this Group Plan only for those expenses which exceed the amount payable by Medicare Part A.
2. If expenses are incurred for which benefits are payable by both this Group Plan and Medicare Part B, the Health Plan will reduce the benefits payable by this Group Plan by the amount of benefits payable for those expenses by Medicare Part B.

For a Covered Person who is under age 65 and eligible for Medicare, the benefits payable by this Group
Plan will be reduced so that not more than 100% of the expenses incurred are paid jointly by this Group Plan and Medicare.

The Health Plan shall not be liable to the Employer or to any individual covered under this Group Plan due to any nonpayment of primary benefits resulting from any failure of performance of the Employer's obligations as set forth in this section.

Conformance With Federal Law
This Medicare Secondary Payer Section shall be subject to modification if necessary to conform to, or comply with, and interpreted with reference to, the requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under this Group Plan.

2.0 CLAIM PROVISIONS

2.1 REIMBURSEMENT FOR PARTICIPATING AND NON-PARTICIPATING PROVIDER SERVICES

The Health Plan will provide or arrange for covered services to be received from Participating Providers on a direct service basis and publish these providers in the Plan's Provider Directory. If a Covered Person receives covered services from a Participating Provider, the Health Plan will pay the Health Care Provider directly for all care received. The Covered Person will not have to submit a claim for payment, and will be responsible only for any applicable Deductibles, Copayments or Coinsurance.

In the event the Covered Person receives emergency services or urgent care from a Non-Participating Provider while inside or outside the Service Area, the Covered Person will be reimbursed for the cost of the service at the Health Plan's Allowable Fee Schedule, less applicable cost-share amounts. The covered person will also be responsible for any balance between the provider's charges and the Health Plan's Allowable Fee Schedule. This balance may be substantial.

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

2.2 POST SERVICE CLAIMS PROCEDURE

It is not expected that a Covered Person will make payment, other than their required cost share, for any benefits provided hereunder. However, if such payments are made, the Covered Person shall make a claim for reimbursement to the Health Plan. In order for a claim for reimbursement to be considered, the Covered Person must provide written proof of any payment made in an acceptable form such as CMS 1500 for physician claims or UB92 for facility claims. Prescription Drug Reimbursement Forms are available from the Health Plan's Customer Service Department.

2.3 TIME LIMIT FOR FILING CLAIMS

Claims for reimbursement must be submitted to the Health Plan within six (6) months from the date on which covered expenses were first incurred.

2.4 CLAIMS PAYMENT

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

The Health Plan shall reimburse all claims or any portion of any claim up to the Allowed Charge

from a Subscriber or a Subscriber's assignees within the regulatory guidelines of Florida State statute. If a claim or a portion of a claim is contested by HFHP, the Subscriber or the Subscriber's assignees shall be notified, in writing, that the claim is contested or denied. The notice (Explanation of Benefits) that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim. Upon receipt of the additional information requested from the Subscriber or the Subscriber's assignees the Health Plan shall pay or deny the contested claim or portion of the contested claim, within the regulatory guidelines of Florida State statute. HFHP shall pay or deny all claims no later than 120 days after receiving the claim an electronic claims and 140 days after receiving a paper claims.

Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. All overdue payments shall bear a simple interest rate as directed by the State of Florida.

2.5 ADVERSE DETERMINATIONS
If reimbursement is denied for any reason, the Covered Person will receive a notice explaining the reason for the denial and the process for filing an appeal.

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

2.7 LEGAL ACTIONS AND LIMITATIONS
No action at law or in equity may be brought to recover under this group plan until at least 60 days after written proof of loss has been filed with the Health Plan. If action is taken after the 60-day period, it must be taken prior to the expiration of the statute of limitations from the date written proof of loss was required to be filed.

2.8 UNUSUAL CIRCUMSTANCES
If the rendering of services or benefits payable under this plan is delayed or impractical due to: (a) complete or partial destruction of network facilities; (b) war; (c) riot; (d) civil insurrection; (e) major disaster; (f) disability of a significant part of Participating hospital and practitioner network; (g) epidemic; (h) labor dispute not involving the Health Plan, Participating hospitals and other Participating Providers, Participating Providers will use their best efforts to provide services and benefits within the limitations of available facilities and personnel. However, neither the Health Plan, nor any Participating Providers shall have any liability or obligation because of a delay or failure to provide such services or benefits. If the rendering of services or benefits under this plan is delayed due to a labor dispute involving the Health Plan or Participating Providers, non- emergency care may be deferred until after the resolution of the labor dispute.

3.0 COMPLAINT, GRIEVANCE & APPEAL PROCEDURES

A Complaint is an informal expression of dissatisfaction related to benefits or services provided under this Plan. A Grievance is a formal complaint regarding service issues or the quality of care provided under this Plan. An Appeal is a formal dispute regarding an Adverse Coverage Determination (denial of coverage or application of cost share). The Health Plan administers an Informal Complaint Procedure, a formal Grievance procedure, and a formal Appeal procedure. All procedures take medical urgency into account.

3.1 INFORMAL COMPLAINT PROCEDURE

Many complaints can be resolved by using the Informal Complaint Procedure, which consists of personal and informal discussion about the problem. The Covered Person or their authorized representative should contact Customer Service at (855) 443-4735with any initial complaint. The Customer Service Representative will make every effort to resolve the problem within three (3) working days. A formal Grievance may also be filed according to the procedure defined below, with assistance provided if necessary.

3.2 GRIEVANCE PROCEDURE

Formal Grievances must be submitted in writing within 180 days of the event causing the Grievance. To file a written Grievance, you or your authorized representative must submit a Grievance containing the following information:

a. The Covered Person's name, address and identification number;
b. A summary of the concern, along with any supporting documentation/medical records;
c. A description of relief sought;
d. The Covered Person's (or legal representative's) signature;
e. The date the Grievance is signed

Written Grievances must be sent to:

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

Fax: 855-328-0053
E-Mail: hfhpinfo@health-first.org

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

3.3 APPEAL PROCEDURES

General Information
If benefits are denied in whole or in part, the Health Plan will provide you or your authorized representative written notice of the denial.

The denial notice will include:

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

For urgent medical situations, an Expedited Appeal procedure is available if applying the standard time frame would jeopardize your health or ability to regain maximum functioning. The Health Plan reserves the right to determine if your situation warrants the expedited process, and will not expedite Appeals for services that have already been received.

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

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

APPEAL PROCEDURE – FIRST LEVEL OF REVIEW

SUBMITTING APPEALS

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

a. The Insured's name, address and identification number;
b. A summary of the concern, along with any supporting documentation/medical records;
c. A description of relief sought;
d. The Insured's signature;
e. The date the Appeal is signed

Written Appeals must be sent to:

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

Fax: (855) 328-0053
E-Mail: HFHPinfo@Health-First.org

Expedited Appeals may be filed verbally by contacting an Appeal Coordinator at (855) 443-4735 (toll-free) any time.

FIRST LEVEL REVIEW TIME FRAMES

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

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

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

Extensions: One fourteen (14) calendar day extension is permitted if additional information is necessary to make a decision on the Appeal, and you or your authorized representative agree to the extension. In such case, information will be requested within the resolution time frames listed above, and forty-five (45) days will be allowed in which the information must be provided. A decision will be made within fifteen (15) days after the information is received, or if the information is not received, when this period has elapsed.

AUTHORIZED REVIEWERS

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

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

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

REQUESTING A SECOND-LEVEL APPEAL REVIEW

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

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

An expedited second-level Appeal process is available if the standard time frame would seriously jeopardize your health or ability to regain maximum functioning, or would subject you to severe pain that cannot be adequately managed without the requested care in the opinion of your Physician. We will decide if the expedited process is needed, and will make a decision within seventy-two (72) hours if the fast process is granted. If your Appeal qualifies for the expedited process, you may also request external review. To request an Expedited Appeal or external review, call Customer Service toll-free at (855) 443-4735.

SECOND-LEVEL REVIEW TIME FRAMES

For standard pre-service Appeals, the Member Assistance Panel Hearing will generally be scheduled within ten (10) calendar days of the request for the second-level review, or when a delay is requested by you or your authorized representative, within thirty (30) days of the second level Appeal request. A decision will be made and written notification will be provided within five (5) calendar days after the hearing.

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

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

EXTERNAL REVIEW

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

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

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

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

Phone: (855) 443-4735
Fax: (855) 328-0053
E-Mail: HFHPinfo@Health-First.org

For standard external review requests, the Health Plan will complete a preliminary review of the request to determine if the Appeal is eligible for external review within five (5) business days of

receipt of the request. For Expedited Appeals (as determined by the Health Plan), this preliminary review will be conducted the same day the request is received.

ELIGIBILITY REQUIREMENTS FOR EXTERNAL REVIEW

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

1. The request for external review is filed by you or your authorized representative;
2. The request is made in the required time frame, as indicated above;
3. The request is made by the correct method (standard requests in writing);
4. You must be (or must have been) Covered under the plan when the item or service was requested (for pre-service Appeals) or when it was received (for post-service Appeals);
5. The Adverse Coverage Determination does not relate to your failure to meet the requirements for eligibility under the terms of this Group Policy; and
6. One of the following has occurred:

    a. The entire internal Appeal process has been completed;
    b. The Health Plan deems the internal Appeal process completed; or
    c. An Appeal meeting expedited criteria has been filed with the Health Plan.

Within one (1) business day after completing the preliminary review, the Health Plan will notify you or your authorized representative in writing of the Appeal's eligibility for external review. If the Appeal is not eligible, the reason(s) for ineligibility will be provided, with contact information for the Employee Benefits Security Administration (866-444-3272). If the request is incomplete, the notification will describe the information needed to complete the request, allowing for submission of the information within the original four-month filing period, or within forty-eight (48) hours after receipt of the notification, whichever is greater.

For Appeals eligible for external review, the Health Plan will assign the case to an Independent Review Organization (IRO) accredited by a nationally-recognized accrediting organization to conduct external review, ensuring against bias by rotating cases between at least three (3) IROs. The IRO will notify you or your authorized representative in writing of the Appeal's acceptance for external review and of their right to submit additional information within ten (10) calendar days of receiving the request. The final decision will be issued within forty-five (45) days after receiving the request. For Expedited Appeals, the IRO will notify you or your authorized representative of the decision as quickly as the individual's medical condition requires, but in no later than seventy-two (72) hours after receiving the request. If the notification is made verbally, written notice will be provided within forty-eight (48) hours after the verbal notice.

ADDITIONAL ASSISTANCE WITH GRIEVANCES AND APPEALS

You or your authorized representative have the right to contact, at any point throughout this process, the State of Florida Department of Financial Services.

Florida's Department of Financial Services:

Department of Financial Services

Division of Consumer Services, 5th Floor
200 East Gaines Street
Tallahassee, Florida 32399-0322
Toll-free: (877) 693-5236
Email: Consumer.Services@myfloridacfo.com

3.4 RIGHT TO LEGAL ACTION

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

The deadline to file legal action is as follows:

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

4.0 COVERAGE PROVISIONS
This section provides important information about the coverage provided under this Small Group Plan, explaining:

1. What guidelines the Covered Person must follow in accessing care;
2. What services and supplies are covered; and
3. What services and supplies are not covered.

4.1 COVERAGE ACCESS GUIDELINES
It is the covered persons responsibility to understand the following sections which explain the role of the Health Plan and the Primary Care Physician, how to access primary and specialty care through the Health Plan, the Primary Care Physician, and what to do if Emergency Services or Care are needed. Coverage access guidelines may differ with a POS plan.

4.1.1 CHOOSING A PRIMARY CARE PHYSICIAN
Although members are not required to elect a Primary Care Physician upon enrollment, the Health Plan strongly recommends you do so. Members are free to choose any Primary Care Physician from the published list of Primary Care Physicians whose practices are open to new members. Selecting a Primary Care Physician does not prevent the Covered Person from obtaining care elsewhere in the network and referrals are not required to access specialty care. A relationship with a Primary Care Physician can enhance the quality of medical care received through coordination and direction of all necessary medical services.

It is also important to note the following:

1. The Covered Person should look to the Primary Care Physician to direct his/her care, and should consider procedures and/or treatment recommended by the Primary Care Physician.

2. Except for Emergency Medical Conditions, all HMO services must be received from Participating Providers (See Definitions) or through another Health Care Provider authorized by the Health Plan.
3. If for any reason the Participating Provider fails to or is unable to provide the Covered Person with services they have agreed to provide, the Health Plan agrees to provide, arrange, and pay for services equivalent to those described in the Covered Services section. However, for HMO members, the use of Non-Participating Providers must be authorized in advance by the Health Plan.

4.1.2 ADDITIONAL HEALTH CARE PROVIDER INFORMATION

1. If a Participating Provider terminates his or her contract with the Health Plan or is terminated by the Health Plan for any reason other than for cause, a Covered Person receiving active treatment may continue coverage and care with that Provider (as long as the terminated provider agrees to continue treating the patient at the contracted reimbursement rate) when Medically Necessary and through completion of treatment of a condition for which the Covered Person was receiving care at the time of the termination until:
   a. the Covered Person selects another treating provider, or during the next open enrollment period, whichever is longer, but not longer than six (6) months after termination of the provider's contract.
   b. the Covered Person, who is pregnant and who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, completes postpartum care.

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

   A Covered Person in active course of treatment should contact the Health Plan to assist in coordinating continued coverage with the terminated provider or transfer the Covered Person to another Participating Provider.

2. When payment is provided for surgical first assisting benefits or services, payment will also be provided for the services of a registered nurse first assistant or a physician assistant who performs such services that are within the scope of their professional license as a substitute for physician services. If a registered nurse first assistant or physician assistant provides such services, the Health Plan will provide reimbursement for such provider and will not also pay for the supervising physician. The Health Plan follows Medicare guidelines on when to pay surgical first assisting benefits.

4.1.3 ACCESSING SPECIALTY CARE FOR HMO MEMBERS

The Health Plan does not require Covered Persons to obtain a referral from the Primary Care Physician prior to seeking services from a participating specialist. However, certain participating specialists will not accept appointments directly from Covered Persons that have not been referred for care. In these instances Covered Persons will first need to see a Primary Care Physician. Although the Health Plan operates as an "Open Access" HMO, it is still strongly recommended that Covered Persons coordinate all care they are receiving from a Specialist with their Primary Care Physician.

If a non-participating specialist is required because services are not available within the participating provider network, the Primary Care Physician or participating specialist will submit a request for authorization of such treatment to the Health Plan.

4.1.4 PRIOR AUTHORIZATION

In order for certain services to be covered, prior approval by the Health Plan is required. This provision includes, but is not limited to, inpatient care, certain diagnostic and medical procedures and all out of network services (except for Emergency Medical Conditions or Urgent Care). Services requiring prior authorization are subject to change without prior notice and at the sole discretion of the Health Plan. A current list of services requiring prior authorization is available through the Health Plan Customer Service Department and is posted on the Health Plan's website at www.healthfirsthealthplans.org.

When prior authorization is required, the Participating Provider must submit a written authorization request with supporting clinical information to the Health Plan for review. The Participating Provider requesting the authorization will be considered an authorized representative of the Covered Person during the prior authorization process. All related communications will be directed from the Health Plan to the requesting Participating Provider, who will communicate with the Covered Person. If authorization is denied for any reason, both the Covered Person and the requesting Participating Provider will receive a notice explaining the reason for the denial and the process for filing an appeal.

Expedited Authorizations

A decision will be made and the requesting Participating Provider will be notified within 24 hours. If additional information is required in order to make a decision the information will be requested from the Participating Provider within 24 hours of the prior-authorization request. The requesting Participating Provider will have 48 hours from the time requested to provide the additional information. A decision will be made and the requesting Participating Provider will be notified within 48 hours after the earlier of (a) the receipt of requested information or (b) the end of the period afforded to submit the information.

Standard Pre-Service Authorizations

A decision will be made and the requesting Participating Provider will be notified within fifteen (15) calendar days. If an extension is necessary due to circumstances beyond the Health Plan' control, a 15-day extension may be applied, for a total of 30 days to render a decision. If the delay is due to additional information being required in order to make a decision, the information will be requested from the requesting Participating Provider within 15 calendar days of the prior- authorization request. The requesting Participating Provider will have 45 calendar days within which to provide the requested information. A decision will be made and the requesting Participating Provider will be notified within 15 calendar days after the earlier of (a) the receipt of requested information or (b) the end of the period afforded to submit the information.

Concurrent Care

If ongoing care has been approved over a period of time or in a specified number of treatments, and the Covered Person or treating Participating Provider wishes to extend the course of treatment, the Covered Person, through their treating Participating Provider, must request the Health Plan to continue the ongoing care at least 24 hours prior to the end of the approved course of treatment. A decision will be made and the treating Participating Provider will be notified within 24 hours of the Health Plan receiving the request.

4.1.5 EMERGENCY AND URGENT CARE SERVICES

Emergency and Urgent Care Services are covered inside the service area and outside the service area, including locations outside the United States and its territories. See Section 2.1 for important claim provisions related to Emergency or Urgent Care obtained from Non-Participating Providers, which limit reimbursement for these services to the Health Plan's Allowable Fee Schedule, less applicable cost-share amounts.

Emergency Care Services
In the event of an Emergency Medical Condition, the Covered Person should seek care at the closest Medical Facility available without regard to the network participation status of the facility. An Emergency Medical condition is defined as:

1. A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
    a. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus. b. Serious impairment to bodily functions.
    c. Serious dysfunction of any bodily organ or part.
2. 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.

Coverage will be provided for medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists. If it is determined that an emergency medical condition exists, the care, treatment, or surgery necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital, is covered. If care is sought for a non-emergency medical condition payment shall be limited to costs for the determination of whether an emergency medical condition existed and no further benefits will be paid. More than one cost share may apply to services provided in an Emergency Room setting. For example, some plans include a cost share for the Emergent Visit and separate cost shares for additional services such as high end imaging if applicable. See your Schedule of Benefits for details.

In the event of an emergency medical condition, the Covered Person or the Covered Person's family should notify the Health Plan as soon as reasonably possible. Only the initial treatment as described above is covered without authorization at Non-Participating facilities for HMO members. All follow-up care must be coordinated to ensure proper coverage under this plan.

Urgent Care
Urgent Care services are covered both inside and outside the service area. Inside the service area, HMO members must utilize Participating Urgent Care Centers. Outside the service area, coverage is provided at a Non-Participating Urgent Care Center or licensed physician office. For HMO members, coverage outside the service area is also limited to care for conditions which, although not life-threatening, could result in serious injury if left untreated and were unforeseeable prior to leaving. Applicable cost share amounts for both in and out of area covered care are listed in the Schedule of Benefits attached to this Certificate.

4.1.6 THE CALENDAR YEAR DEDUCTIBLE (If applicable)

Calendar Year Deductible Requirement

Individual Calendar Year Deductible
This amount, when applicable, must be satisfied by you each Calendar Year, before any payment will be made. Only those charges indicated on claims we receive for Covered Services will be credited toward the individual Calendar Year Deductible and only up to the Allowed Amount. Certain covered services that are subject to a copayment are not subject to the Calendar Year Deductible, as indicated in the Schedule of Benefits.

Family Calendar Year Deductible
If your contract includes a family Calendar Year Deductible, after the family Calendar Year Deductible has been satisfied by your family, neither you nor your Covered Dependents will have any additional Calendar Year Deductible responsibility for the remainder of that Calendar Year.
The maximum amount that any one Covered Person in your family can contribute toward the family Calendar Year Deductible is the amount applied toward the individual Calendar Year Deductible. Note that Participants covered by a qualifying High Deductible Health Plan (Health Savings Account compatible) are not subject to the imbedded individual deductibles described above for Covered Family units. Instead, Family Covered Persons must meet the combined Family Deductible prior to the Health Plan paying a portion towards the cost of Covered Services.

Expenses for non-Covered Services will not count towards the satisfaction of the Calendar Year Deductible. In addition to ineligible expenses, out-of-pocket expenses related to charges for services not covered by this Group Plan, Prescription Drug Cost Share (unless enrolled in an HSA compatible High Deductible Health Plan), any charges in excess of the Allowed Amount, or expenses that relate to services that exceed specific treatment limitations explained in this section or noted in the Schedule of Benefits will **not** count towards satisfying the Calendar Year Deductible Requirement.

Calendar Year Deductible credit is extended to newly enrolled Participants. Credit will be given for any portion of a deductible satisfied under the prior carrier in the current Calendar Year up to the deductible of the new plan. Evidence supporting the credit amount must be supplied. Acceptable evidence may be in the form of an official company Explanation of Benefits statement.

4.1.7 COPAYMENTS (If applicable)
For some services, the Covered Person is responsible for paying a flat dollar amount for Covered Services. This dollar amount is referred to as a Copayment. Copayments are due at the time of service. The Health Plan is not responsible for coordinating the collection of co- payments. The provider is responsible for the collection of co-payments at the time services are rendered. The Copayment requirements for this Group Plan are set forth in the Schedule of Benefits, and will apply in full, regardless of the amount of the actual charges. For outpatient services, copayments are “stackable”, meaning the copayment for each service will apply. For example, if an MRI is provided in the Emergency Room, both the Emergency Room copayment and the MRI copayment will apply.

The total cost share a Covered Person is responsible for in any single Calendar Year will be limited to an Out-of-Pocket Maximum Limit as set forth in the Schedule of Benefits. Prescription

Drug Cost Share does not count towards the Out-of-Pocket Maximum Limit, unless enrolled in an HSA compatible High Deductible Health Plan.

4.1.8 THE COINSURANCE PERCENTAGE (If applicable)
The Covered Person may be responsible for paying a percentage of Covered Services in addition to the deductible in any Calendar Year. This percentage that the Covered Person is responsible for is called the Coinsurance Percentage. The Coinsurance Percentage for this Group Plan is shown in the Schedule of Benefits.

When charges are incurred for covered services or supplies provided by Participating Providers, this Group Plan calculates all coinsurance amounts by applying the Coinsurance Percentage to the amount the Participating Provider has agreed to accept for that service or supply in the negotiated fee schedule.

4.1.9 OUT-OF-POCKET MAXIMUM EXPENSE LIMIT
The Out-of-Pocket Maximum Expense Limit is the maximum amount of expenses that must be paid in a Calendar Year by Covered Single or Family Persons before this Group Plan pays Covered Services at 100% of the Allowance determination for the remainder of that Calendar Year.

Out-of-pocket expenses related to charges for services not covered by this Group Plan, Prescription Drug Cost Share (unless enrolled in an HSA compatible High Deductible Health Plan), any charges in excess of the Allowance determination, or expenses that relate to services that exceed specific treatment limitations explained in this section or noted in the Schedule of Benefits will **not** count toward satisfying the Out-of-Pocket Maximum Expense Limit.

The application of any specific service limits or specific benefit maximums noted in the Covered Services section or in the Schedule of Benefits is not affected by the action of out-of-pocket maximums. These specific service provisions will still apply after the out-of-pocket maximums are satisfied.
High Deductible Health Plan Participants: In order to meet federal guidelines these plans do not contain imbedded individual out-of-pocket maximums for Family members. Family Covered Persons must meet the combined Family out-of-pocket maximum prior to the Health Plan paying 100% of the allowable cost of Covered Services.

4.1.10 LIFETIME BENEFIT MAXIMUM
Does not apply to Essential Health Benefits (to be defined by the Federal Government) beginning with Plan Years effective September 23, 2010 or later.

4.1.11 GROUP PLAN REPLACEMENT
If this Group Plan immediately replaces another Group Plan, each Covered Person who was covered by the prior Health Plan, (e.g. employees, dependents, COBRA continuant, Covered Person on sick leave, out ill, or on maternity leave) will be covered by the Health Plan and the following rules will apply:

Extension of Benefits Upon Replacement of the Entire Group Plan
The Small Employer's previous employer-related health plan, health insurance plan, or other benefit arrangement may be required to provide certain benefits to certain Covered Persons under an extension of benefits provision. In no event under this Group Plan, shall the Health Plan pay any claims for services or supplies that are covered under any provision in the prior

health plan relating to extension of benefits, until the extension of benefits for the condition under the prior plan ends for the Covered Person.

4.1.12 DISCRETIONARY AUTHORITY

The Health Plan has the sole discretionary authority to determine eligibility, to construe all terms of this Group Plan, and to make decisions concerning claims for benefits under the terms of this Group Plan. The Health Plan may delegate this discretionary authority to other persons or entities with respect to the administration of this Group Plan and is not required to provide notice or obtain approval of the Covered Person or Large Employer.

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

4.1.13 CONFORMITY WITH STATE STATUTES

The validity, construction, and interpretation of this Certificate of Coverage shall be governed by the laws of the State of Florida to the extent there is no conflict with applicable federal law and regulations with respect to an ERISA-Regulated Plan.

4.2 POINT-OF-SERVICE (POS) PROVISIONS (If Applicable)

These provisions apply exclusively to Point-of-Service (POS) plans that may be purchased by the Employer Group at an additional expense. The attached Schedule of Benefits will identify whether or not you have a traditional HMO benefit plan or a more flexible POS benefit plan. POS plans allow covered persons to seek covered services from participating and non- participating providers. A higher cost share is typically associated with seeking care from non- participating providers and the Covered Person will be responsible for expenses determined to be greater than the Health Plan's Allowable Fee Schedule.

All services and supplies covered under the out-of-network benefits portion of the Group Plan must be medically necessary and may require prior authorization approval by the Health Plan. Under the out-of-network benefits section, the covered person is ultimately held responsible for making sure services have been approved in advance of seeking treatment or risk full responsibility for the costs incurred. Finally, all service limits and benefit maximums are calculated by using the sum total of benefit and services
provided both in-network and out-of-network combined.

4.2.1 POS GUIDELINES FOR COVERED SERVICES AND BENEFITS

Access: Covered Persons are encouraged to select a Primary Care Physician, but are not required to do so. Covered Persons may chose to self refer to a provider who is not participating with the Health Plan or to a participating provider for Covered Services and Supplies. Service limits and benefit maximums for Non-Essential Health Benefits (to be defined by the Federal Government) are calculated by using the sum total of benefits and services provided both in and out-of-network.

Covered Person Financial Responsibility: In general, when a Covered Person utilizes covered services, the financial responsibility is any applicable deductible, copayment or coinsurance. Payment may be required at the time services are rendered. A Covered Person is responsible for satisfying the calendar year deductible before the coinsurance applies. Any
amount charged by a Non-Participating Provider that is in excess of the Allowable Fee Schedule

is the sole responsibility of the Covered Person and does not apply towards the deductible, coinsurance or maximum out of pocket expense. When the maximum out of pocket expense is satisfied, the Covered Person will continue to be responsible for any charges in excess of the Allowable Fee Schedule for Non-Participating Providers. When seeking out-of-network services, Participant's are encouraged to negotiate acceptance of the Health First fee schedule in advance of seeking treatment in order to lower their out-of-pocket costs.

Medical Necessity: All services and supplies covered under the out-of-network benefits must be Medically Necessary as defined in the Group Plan. Some services and supplies require approval by the Health Plan prior to the services being rendered.

Prior Authorization for Covered Services: In order to determine whether services and supplies are Medically Necessary, certain services require approval from the Health Plan BEFORE services are received. A Covered Person should verify with his/her physician that the service has received Prior Authorization. The Covered Person will be responsible for the cost of services and supplies if Prior Authorization is NOT obtained regardless of whether such services are deemed Medically Necessary.

Services that require Prior Authorization are detailed in the Health Plan's *Authorization List*, available on the Health Plan's website at www.HealthFirstHealthPlans.org, or by contacting Customer Service at (855) 443-4735. The Authorization List is updated semi-annually, but is subject to change without notice at the Health Plan' discretion.

5.0 COVERED SERVICES

This section describes the services that are covered under this Plan and those that are not covered. It is important that this whole section be reviewed to be sure both Covered Service details and the Limitations and Exclusions are understood. **In addition, important information is contained in the Schedule of Benefits.**

ALL OF THESE PROVISIONS SHOULD BE READ CAREFULLY TO UNDERSTAND THE BENEFITS PROVIDED UNDER THIS GROUP PLAN.

5.1 COVERED SERVICES

The services and supplies listed below will be considered Covered Services under this Group Plan if the service is:

1. Set forth Within the Covered Services categories in this section;
2. Received from or provided by Participating Providers, except for Urgent or Emergency Services and Care, unless covered under a POS plan.
3. Actually rendered while coverage under this Group Plan is in force;
4. Medically Necessary, as defined in this Group Plan; and
5. Not specifically limited or excluded under this Group Plan.

Covered persons are responsible for the cost share listed in the attached Schedule of Benefits for each category of Covered Services. The payment of expenses for Covered Services received from Non-Participating Providers is subject to the Health Plan's Allowance guidelines (See the Allowance provisions).

5.2 HOSPITAL SERVICES

The services and supplies listed below shall be considered Covered Services when furnished to a Covered Person at a Hospital on an inpatient or outpatient basis in accordance with all other plan provisions included herein. Covered Services are subject to the cost share which may consist of Deductibles and/or Coinsurance and Copayments noted on the Schedule of Benefits:

1. Room and board for semi-private accommodations, unless the patient must be isolated from others for documented clinical reasons;
2. Confinement in an intensive care unit including cardiac, progressive, and neonatal care;
3. Covered Physician services provided while in an in-patient setting.
4. Miscellaneous hospital services;
5. Services provided by a birthing center licensed pursuant to Florida Statutes, chapter 383.30-383.335, when such facilities are available within the Health Plan’s service area;
6. Routine nursery care for a newborn child;
7. Drugs and medicines administered by the Hospital;
8. Respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
9. Rehabilitative services, when hospitalization is not primarily for rehabilitation;
10. Use of operating room and recovery rooms;
11. Use of emergency rooms;
12. Intravenous solutions;
13. Dressings, including ordinary casts, splints and trusses;
14. Anesthetics and their administration;
15. Transfusion supplies and equipment;
16. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., electrocardiogram (EKG);
17. Imaging services, including CT Scans, Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) Scans, Nuclear Cardiology Studies;

18. Outpatient Observation
19. Chemotherapy treatment for proven malignant disease; and
20. Other Medically Necessary services and supplies.

5.3 Ambulatory Surgical Center Services and Other Outpatient Medical Treatment Facilities

The services and supplies listed below will be considered Covered Services when furnished to a Covered Person at a Participating Provider (or non-participating provider for POS members), ambulatory surgical center, or other outpatient medical treatment facility if authorized and obtained in accordance with all other plan provisions included herein:

1. Use of operating room and recovery rooms;
2. Respiratory or inhalation therapy (e.g., oxygen);
3. Drugs and medicines administered at the Ambulatory Surgical Center or other Outpatient Medical Treatment Facility;
4. Intravenous solutions;
5. Dressings, including ordinary casts, splints or trusses;
6. Anesthetics and their administration;
7. Transfusion supplies and equipment;
8. Diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., electrocardiogram (EKG);
9. Imaging services, including CT Scans, Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) Scans;
10. Chemotherapy treatment for proven malignant disease; and
11. Other Medically Necessary services and supplies.

5.4 MEDICAL SERVICES

The medical services and supplies listed below will be considered Covered Services if authorized in advance by the Health Plan and provided or authorized in accordance with all other plan provisions included herein. Covered Services are subject to the Copayments, Coinsurance and/or Deductibles noted on the Schedule of Benefits:

Allergy treatment, including allergy testing, desensitization therapy and allergy immunotherapy, including hypo sensitization serum.

Ambulance services are provided for emergent (does not require advance authorization) and non-emergent (in accordance with Medicare guidelines) situations if authorized in advance. Ambulance services by boat, airplane, or helicopter will be reimbursed at the Allowed Charge level for a ground vehicle when:

1. The pick-up point is inaccessible by ground transportation;
2. Speed in excess of ground vehicle speed is critical; or
3. The travel distance involved in getting the Subscriber to the nearest Hospital that can provide proper care is too far for medical safety.

Anesthesia services, when administered by a Health Care Provider and necessary for a surgical procedure.

Blood, including whole blood, blood plasma, blood components, and blood derivatives, unless replaced.

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

Coverage for mastectomies includes:

1. all stages of reconstruction of the breast incident to the mastectomy;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Cancer diagnosis and treatment, unless otherwise excluded, on an inpatient or outpatient basis, including chemotherapy treatment, x-ray, cobalt, and other acceptable forms of radiation therapy, microscopic tests or any lab tests or analysis made for diagnosis or treatment.

Cancer screenings Annual screenings limited to the following: breast, cervical, and colorectal. ***This benefit is considered a Preventive Health Service and is not subject to cost share as set forth in the Schedule of Benefits****.* Skin and prostate cancer screenings are covered with applicable cost-sharing amounts.

Casts and splints when part of the treatment provided in a health care provider facility, provider office or in a Hospital emergency room. This does not include the replacement of any of these items.

Child health supervision services including periodic Physician-delivered or Physician-supervised services from the moment of birth up to the 17th birthday are covered as follows:

1. A newborn's first examination in the Hospital. The examination must be provided and billed by a Physician other than the delivering obstetrician or anesthesiologist;
2. Periodic examinations, which include a history, a physical examination, developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child;
3. Oral and/or injectable immunizations;
4. Vision and hearing screening by the Primary Care Physician; and
5. Laboratory tests normally performed for a well child.

These services must conform to prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Benefits may be limited to one visit payable to one provider for all of the services provided at each visit. ***This benefit is considered a Preventive Health Service and is not subject to cost share as set forth in the Schedule of Benefits.***

Cleft Palate and Cleft Lip treatment is provided for a dependent under age nineteen (19). Coverage includes medical, dental, speech therapy, audiology, and nutrition services if the Primary Care Physician or treating physician prescribes such services. Coverage is subject to benefit limitations listed in the Covered Services and Exclusions and Limitations sections of this Group Plan.

Concurrent Physician Care for approved procedures, including surgical assistance, provided a) the additional Physician actively participates in the Covered Person's treatment, b) the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted, and c) the Physicians have different specialties or have the same specialty with different sub-specialties.

Congenital and developmental abnormality, provided the treatment, or plastic and reconstructive surgery is for the restoration of bodily function, or the correction of a deformity resulting from disease, or congenital or developmental abnormalities.

Dental Treatment in a Hospital or Ambulatory Surgical Center, general anesthesia and hospitalization services in connection with necessary dental treatment or surgery for:

1. A dependent child under age eight (8) whose treating physician, in consultation with the dentist, determines necessary dental treatment is required in a hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
2. A Covered Person who has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any medically necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition. The Health Plan must authorize the use of general anesthesia and hospital services prior to the treatment. Coverage does not include diagnosis or treatment of dental disease, or the services of the dentist or oral surgeon.

Dermatological Services including dermatological office visits or minor procedures and testing. Services or testing not considered minor or routine in nature may require prior authorization.

Diabetes Outpatient Self-Management Services including diabetes outpatient self-management training and education Services and nutrition counseling (including all Medically Necessary equipment and supplies) to treat diabetes, if the Covered Person's Primary Care Physician, or the treating physician who specializes in treating diabetes, certifies that the equipment, supplies, or services are Medically Necessary. In order to be covered, diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board certified Physician specializing in endocrinology at an approved facility. Additionally, in order to be covered, a licensed dietitian must provide nutrition counseling. Covered Services may also include the trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Diagnostic Services including procedures, lab tests, radiologic exams and their interpretation. ***Certain diagnostic services as set forth in the Schedule of Benefits are defined as Preventive Health Services and are not subject to cost share if billed as such.***

Diagnostic and surgical procedures involving bones or joints of the jaw and facial region are covered, if under acceptable medical standards, such procedures or surgery is Medically Necessary to treat conditions caused by congenital or developmental deformity, disease, or injury. This coverage does not include coverage for care or treatment of the teeth or gums or for surgical procedures for cosmetic purposes.

Durable medical equipment that is determined by the Health Plan and the Covered Person's treating Physician to be Medically Necessary for the care and treatment of a Condition covered under this Group Plan. The specified durable medical equipment will not, in whole or in part, serve as a comfort or convenience item for the Covered Person or be available over the counter. Supplies and service to repair medical equipment may be a covered Benefit only if the Covered Person owns the equipment or is purchasing the equipment under a maintenance agreement with the Health Plan. The Health Plan' allowance for durable medical equipment is based on the most cost effective durable medical equipment which meets the Covered Person's needs, as determined solely by the Health Plan. At the Health Plan option, the cost of either renting or purchasing will be covered. If the cost of renting is more than its purchase price, only the cost of the purchase is considered a Covered Service.

Enteral/Parenteral and Oral Nutrition Therapy. Enteral and Parenteral Nutrition is covered when considered medically necessary by the Health Plan and authorized in advance. For infants, oral nutritional formula prescribed by a physician is covered for the treatment of inborn errors of metabolism or inherited metabolic diseases, including, but not limited to, phenylketonuria (PKU). Coverage to treat inherited disease of amino acids and organic acids up to a dependent's 30th birthday shall include coverage for food products modified to be low protein when prescribed by a physician. Other oral nutrition is not covered. Coverage for enteral, parenteral, or oral nutrition and any related supplies is subject to a separate calendar year maximum benefit of $2,500.

Eye care, limited to the following:

1. Initial glasses or contact lenses following cataract surgery (in accordance with Medicare guidelines); and
2. Physician Services to treat an injury to or disease of the eyes.

Family Planning, including sterilizations (tubal ligation and vasectomies) and intrauterine devices, including their insertion and removal. Oral contraceptives, diaphragms and Depo Provera injections may be covered under a separate Prescription Drug Rider if attached to this Certificate.

Genetic Testing, when considered medically necessary by the Health Plan and authorized in advance.

Hemodialysis for renal disease, including the equipment, training and medical supplies required for effective home dialysis.

Human Growth Hormone Therapy Human growth hormone will be provided for Covered Persons with Growth Hormone Deficiency, Turner Syndrome, Chronic Renal Insufficiency and as determined Medically Necessary by the Health Plan.

Imaging Services, including CT Scans, Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Nuclear Studies are provided when authorized in advance.

Immunizations, when Medically Necessary and not listed as an Exclusion, including flu shots.

Insulin, including the needles and syringes needed for insulin administration. However, the Covered Person must have a Physician's prescription for such supplies on record with the pharmacy where the supplies are purchased.

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

1. A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.
2. One mammogram annually for any woman who is 40 years of age or older. This is considered a Preventive Health Service and is not subject to cost share as set forth in the Schedule of Benefits.
3. Additional screening mammograms for any woman who is at risk of breast cancer because of a personal or family history, or because of having biopsy-proven benign breast disease (subject to cost-share),
4. Diagnostic mammograms for follow-up to a clinical or radiological abnormality (subject to cost-share).

Newborn childcare services received on an inpatient or outpatient basis. These services include post-delivery care including newborn assessments, physical assessments, and the performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards. Post-delivery care may be provided at the hospital, at the attending physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. Coverage includes the services provided in a licensed birth center and the services of certified nurse-midwives and midwives licensed pursuant to Florida Statutes, Chapter 467 when such services are available within the Health Plans' service area.

Newborn hearing screening at birth, and any Medically Necessary follow-up reevaluations leading to diagnosis are covered through age 12 months. Treatment and services covered under this Group Plan and delivered or authorized by the child's treating Physician will be provided to any Covered Dependent child diagnosed as having a permanent hearing impairment. ***This benefit is considered a Preventive Health Service and is not subject to any cost share as set forth in the Schedule of Benefits.***

Obesity treatment - Anorexiant medications are covered when prescribed according to the Health Plan prior authorization criteria. Physician directed individual preventive medicine counseling for obesity management by network providers is also covered.

Obstetrical and maternity care received on an inpatient or outpatient basis including Medically Necessary prenatal and postnatal care of the mother including one routine ultrasound without prior authorization. Benefits include post-delivery care including a postpartum assessment, a physical assessment of the mother, and the performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards and may be provided at the hospital, at the attending physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. Coverage includes the services provided in a licensed birth center and the services of certified nurse- midwives and midwives licensed pursuant to Florida Statutes, Chapter 467 when such services are available within the Health Plans' service area.

Orthotics - The Health Plan will cover the original arch support or orthotic device/appliance, and replacement of the device, for children under the age of 19 if the original need for the

device/appliance was for congenital deformity and if the replacement is due to growth or change.

Osteoporosis Screening, Diagnosis, and Treatment
Screening, diagnosis, and treatment of osteoporosis for high-risk individuals is covered, including, but not limited to:

1. estrogen-deficient individuals who are at clinical risk for osteoporosis;
2. individuals who have vertebral abnormalities;
3. individuals who are receiving long-term glucocorticoid (steroid) therapy;
4. individuals who have primary hyperparathyroidism; or
5. individuals who have a family history of osteoporosis.

Osteoporosis screening for women 60 or older is considered a Preventive Health Service and is not subject to cost share as set forth in the Schedule of Benefits.

Oxygen, including the use of standard equipment for its administration as allowed by Medicare guidelines. The Health Plan reserves the right to monitor a Covered Person's use of oxygen to assure its safe and medically appropriate use.

Pain Management services that are determined to be Medically Necessary.

Pap smears, which are provided as a preventive service, are covered as part of a periodic health assessment exam in the Preventive and Reproductive Care Services Benefit set forth in the Special Services section.

Pathologist services on an inpatient or outpatient basis.

Prescription drugs (out-patient). Outpatient prescription drugs are covered if a Prescription Drug Rider is attached to this Certificate. All other plan requirements, including medical necessity, must also be met for the prescription drugs to be a covered benefit. The Rider describes in detail the Coverage provided therein, and the Health Plan retains the right to modify the Rider from time to time without notice.

Prosthetic devices (external), The Covered Person’s provision of an initial prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects is covered as is repair or replacement due to anatomical change, a change in the patient’s medical condition or the natural growth of a child, when such device is pre-authorized by the Health Plan. Instruction and appropriate services required for the Covered Person to properly use the item (such as attachment or insertion) are covered. The Health Plan reserves the right to provide the most cost efficient and least
restrictive level of service or item that can safely and effectively be provided. Coverage is also provided for prosthetic devices incidental to a covered mastectomy.

Radiologist services on an inpatient or outpatient basis.

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

Routine costs associated with clinical trials may be covered:

When member eligibility requirements are met
Subject to coverage provisions, limitations and exclusions;
When prior authorization is received for services that require prior authorization in advance;
When received from contracted providers, or non-contracted providers when required in order to participate in the trial. Coverage for items or services obtained from non-contracted providers is limited to The Health Plan' allowable fee schedule. Members may be responsible for charges in excess of this amounts.

The following are not considered routine costs, and are not covered:

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

Surgical procedures that are Medically Necessary, not excluded, and performed by a Physician on an inpatient or outpatient basis.

Well Woman Annual Exam, an annual well woman gynecological exam is covered at a Participating obstetrician/gynecologist or Primary Care Physician's office. ***This benefit is considered a Preventive Health Service if billed as such and is not subject to cost share as set forth in the Schedule of Benefits.***

5.5 SPECIAL SERVICES

The special services and supplies listed below will be considered Covered Services if provided by and authorized in accordance with all other plan provisions included herein, subject to the service limitations described below or in the Schedule of Benefits:

Alcohol and Substance Abuse Treatment, services and supplies provided by, or under the supervision of, or prescribed by a licensed Physician or licensed Psychologist. The program must be accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the State of Florida for the treatment of alcohol or drug dependency. The services covered are as follows and benefits are limited as specified in the Schedule of Benefits:

1. Inpatient treatment for the acute stages of substance abuse or detoxification is provided in a general specialty or rehabilitative Hospital and not a Residential Treatment Facility; and,
2. Outpatient care services provided or prescribed by, or under the supervision of a licensed Physician or licensed Psychologist. Detoxification services and supplies are not Covered Services when provided on an outpatient basis.

Erectile Dysfunction Treatment, when deemed medically necessary and authorized in advance by the Health Plan. Erectile Dysfunction drugs may be excluded under applicable Prescription Drug Riders.

Fitness Center Memberships, to assist all Members age 13 and older with maintaining or improving their health status, are available exclusively at fitness centers contracted as Participating Providers. Note a physician release may be required prior to accessing this benefit

and continued eligibility for this program is subject to separate rules of conduct as established by the participating facilities.

Home health care services are covered when provided by a home health agency, if:

1. The skilled service is required; and
2. The skilled service is medically necessary; and
3. The skilled care is intermittent or being provided in lieu of hospitalization.

Home health services include:

1. Intermittent skilled nursing care by a registered nurse or licensed practical nurse;
2. Physical therapy, by a registered physical therapist or licensed physical therapy assistant;
3. Occupational therapy by a registered occupational therapist or licensed occupational therapy assistant;
4. Speech therapy by a registered speech language pathologist;
5. Assistance with Activities of Daily Living by a home health aide when provided as an adjunct to the above skilled care;
6. Supplies as needed to provide the covered care to the extent they would have been covered if under hospital confinement;

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

If the Covered Persons condition does not warrant the services being provided, or if the services are custodial in nature, the services will be denied. Covered home health care services under this Benefit do not include any services that would not have been covered had the Covered Person been confined in a hospital.

Coverage is limited to 3 intermittent visit(s) per day provided by a participating home health agency; 1 visit equals a period of 4 hours or less. Subject to 60 visits maximum per calendar year as outlined in the Schedule of Benefits.

Hospice Services, when hospice services are the most appropriate and cost effective treatment. Covered Persons who are diagnosed as having a terminal illness with a life expectancy of six months or less may elect hospice care for such illness instead of the traditional services covered under this Group Plan.

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

1. Home hospice care, comprised of:
    a. Physician services and part-time or intermittent nursing care by a registered nurse or licensed practical nurse;
    b. Home health aides;
    c. Inhalation (respiratory) therapy;
    d. Medical social services;
    e. Medical supplies, drugs and appliances;

f. Medical counseling for the terminally ill Covered Person; and
g. Physical, Occupational and Speech Therapy if approved by the Health Plan as appropriate for special circumstances.

Inpatient hospice care in a hospice facility, Hospital or Skilled Nursing Facility, if approved in writing by the Health Plan, including care for pain control or acute chronic symptom management. Covered hospice services do not include bereavement counseling, pastoral counseling, financial or legal counseling, or custodial care.

The hospice treatment program must:
1. Meet the standards outlined by the National Hospice Association; and
2. Be recognized as an approved hospice program; and
3. Be licensed, certified, and registered as required by Florida law; and
4. Be directed by a Physician and coordinated by a registered nurse, with a treatment plan that provides an organized system of hospice facility care; uses a hospice team; and has around-the-clock care available.

Mental and Nervous Disorders Treatment. Expenses for the services and supplies listed below for the treatment of Mental and Nervous Disorders will be considered Covered Services if provided to the Covered Person by a Physician, Psychologist, or Mental Health Professional:
1. Inpatient confinement or Partial Hospitalization in a Hospital, or a Psychiatric Facility for the treatment of a Mental and Nervous Disorder if authorized in advance. If Partial Hospitalization services or a combination of inpatient and partial Hospitalization services are rendered, the total benefits paid for all such services combined will not exceed the benefit limits shown in the Schedule of Benefits. Two days of Partial Hospitalization will count as one day towards the Inpatient Mental and Nervous Disorder benefit. Partial Hospitalization services must be provided under the direction of a licensed Participating Physician.
2. Outpatient treatment provided by a licensed psychiatrist, psychologist, mental health professionals which includes clinical social workers, marriage and family therapists, or mental health counselors, for a Mental and Nervous Disorder, including diagnostic evaluation and psychiatric treatment, individual therapy, and group therapy. Coverage is limited as shown in the Schedule of Benefits.

Pre-admission tests when ordered by a physician. However, the following conditions must be met:
1. The admission to the Hospital or the scheduled outpatient surgery must be confirmed in writing by the Health Plan before the testing occurs.
2. The tests must be performed within 7 days before admission to the Hospital or the outpatient surgery center.
3. The tests are performed in a facility accepted by the Hospital in place of the same tests that would normally be done while Hospital confined.
4. The tests are not duplicated in the Hospital to confirm diagnosis.
5. The Covered Person is subsequently admitted to the Hospital or the outpatient surgery is performed, except if a Hospital bed is unavailable or because there is a change in the Covered Person's Condition which would preclude performing the procedure.

Preventive medical and gynecological services (in accordance with recommendations published by the US Preventive Services Task Force that have an A or B rating. A current list of recommended preventive services is available at the U.S. Department of

Health & Human Services' (DHHS') Agency for Healthcare Research and Quality's (AHRQ's) website at http://www.ahrq.gov/clinic/prevenix.htm

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

This benefit is considered a Preventive Health Service if billed as such and is not subject to cost share as set forth in the Schedule of Benefits.

Rehabilitative Outpatient Therapy Services. Outpatient therapies listed below may be Covered Services when ordered by a Physician or other health care professional licensed to perform such services. The Health Plan must specifically approve a written plan of treatment submitted by the Covered Person's Physician. The outpatient therapies listed in this category are in addition to the Physical, Occupational and Speech, and Cardiopulmonary Therapy benefits listed in the Home Health Care, Hospital, and Skilled Nursing Facility categories herein.

1. Physical Therapy (PT) - Short term services provided by a Physician or Licensed Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Covered Condition are covered.

2. Occupational Therapy (OT) - Short term services provided by a Physician or Occupational Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Covered Condition are covered.

3. Speech Therapy (ST) - Short term services of a Physician, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or reduce impairment of speech resulting from a Covered Condition are covered.

   *PT, OT and ST are covered only for conditions of new onset that interfere with normal activities of daily living.

4. Cardiac and Rehab - Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Rehabilitation, for the purpose of aiding in the restoration of optimal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery are covered.

5. Pulmonary Rehab-Services provided under the supervision of a Physician, or an appropriate Provider trained for Pulmonary Rehab, for the purpose of reducing symptoms, optimizing function, and stabilizing restrictive or obstructive lung disease processes.

Visit limits for all outpatient therapies are dependent upon the nature and severity of the impairment. Ongoing therapy for chronic conditions is not a covered benefit. All therapy services must meet medical necessity criteria for short term acute therapy.

Request for Second Medical Opinion

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

1. The Covered Person disagrees with a Physician's opinion regarding the reasonableness or necessity of a surgical procedure; or, the treatment is for a serious injury or illness;

2. For HMO members, second opinions by Non-Participating Physicians must be authorized by the Health Plan in advance. If further diagnostic tests are required, The Health Plan reserves the right to require such testing to be performed in network. Out- of-network services of any kind must be authorized by the Health Plan in advance.
3. The Covered Person will pay applicable cost sharing amounts for a second opinion by a Participating Physician;
4. The Health Plan will pay 60% of the Allowed Charge (150% of the Medicare Fee Schedule) for a second opinion by a Non-Participating Physician. Under both HMO and POS plans, the Covered Person shall be responsible for the balance of such charges, if any.
5. Only one second opinion is covered for the condition being evaluated, unless the first two opinions substantially disagree. If the opinions disagree, a third opinion will be covered according to the provisions contained in this section.
6. A maximum of three second opinions may be covered for any one condition in a Calendar Year. Additional second opinions may be authorized at the sole discretion of the Health Plan.
7. The Covered Person's Physician and the Health Plan's Medical Director's judgment concerning the treatment shall be controlling, after review of the second opinion, as to the obligations of the Health Plan;
8. Any treatment, including follow-up treatment pursuant to the second opinion must be authorized by the Health Plan if prior authorization is required for the service.

Skilled nursing facility services are covered only if a written plan of treatment is submitted by a Physician and only if the Health Plan agrees that such skilled level services are being provided in lieu of hospitalization or continued hospitalization. If provided in the Skilled Nursing Facility, covered expenses include room and board; respiratory therapy (e.g., oxygen); drugs and medicines administered while an inpatient; intravenous solutions; dressings, including ordinary casts; anesthetics and their administration; transfusion supplies and equipment; diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., electrocardiogram (EKG)); chemotherapy treatment for proven malignant disease; and other Medically Necessary services and supplies. Services must be skilled level services, and must be ordered by and provided under the direction of a Physician.

If a Covered Person is a resident of a continuing care facility certified under chapter 651 or a retirement facility consisting of a nursing home or assisted living facility, the Covered Person's PCP must refer the Covered Person to that facility's skilled nursing unit or assisted living facility if requested by the Covered Person and agreed to by the facility; if the PCP finds that such care is medically necessary; if the facility agrees to be reimbursed at the Health Plan's contracted rate negotiated with similar providers for the same services and supplies; and if the facility meets all guidelines established by the Health Plan related to quality of care, utilization, referral authorization, and other criteria applicable to providers under contract for the same services. If the Health Plan enrolls a new Covered Person who already resides in a continuing care facility or retirement facility as described herein, and that Covered Person's request to reside in a skilled nursing unit or assisted living facility is denied, the Covered Person may use the Grievance Process outlined in the Complaint, Grievance and Appeal Section of this Certificate.

Spine and Back Disorder Chiropractic Treatment, consisting of services by Physicians for manipulations of the spine to correct a slight dislocation of a bone or joint. The Schedule of Benefits sets forth the maximum number of visits covered on a calendar year basis.

Transplantation of a covered tissue and organ transplant, as defined below and approved by the Health Plan, subject to those conditions and limitations described below.

Transplantation includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. The Health Plan will pay benefits only for services, care and treatment received for or in connection with the approved transplantation of the following human tissue or organs:

1. Cornea;
2. Heart;
3. Heart-lung combination;
4. Liver;
5. Kidney;
6. Lung-whole single or whole bilateral transplant;
7. Pancreas;
8. Pancreas transplant performed simultaneously with a kidney transplant; or
9. Bone Marrow Transplant, as defined in the Definitions section. The Health Plan will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for the Covered Person and will be subject to the same limitations and exclusions as would be applicable to the Covered Person. Coverage for the reasonable expenses of searching for the donor will be limited to a search among immediate family members and donors identified though the National Bone Marrow Donor Program.

This transplant benefit is subject to Prior Authorization and as such the Covered Person or the Covered Person's Physician must notify the Health Plan in advance of the Covered Person's initial evaluation for the procedure in order for the Health Plan to determine if the transplant services will be covered. For approval of the transplant itself, the Health Plan must be given the opportunity to evaluate the clinical results of the evaluation. Such evaluation and approval will be based on written criteria. If approval is not obtained, benefits will not be provided for the transplant procedure.

No benefit is payable for or in connection with a transplant if:

1. The organ or diagnosis involved is not listed above.
2. The Health Plan is not contacted for authorization prior to referral for transplant evaluation of the procedure.
3. The Health Plan does not approve coverage for the procedure.
4. The transplant procedure is performed in a facility that has not been designated by the Health Plan as an approved transplant facility.
5. Expenses are eligible to be paid under any private or public research fund, government program, or other funding program, whether or not such funding was applied for or received.
6. The expenses related to the transplantation of any non-human organ or tissue.
7. The expenses related to the donation or acquisition of an organ for a recipient who is not covered by the Health Plan, except as specifically covered herein for bone marrow transplants only.
8. A denied transplant that is performed; this includes follow up care, immunosuppressive drugs, and complications of such transplant.
9. Any bone Marrow Transplant, as defined herein, which is not specifically listed in Rule 59B-127.001 of the Florida Administrative Code or any successor or similar rule or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and

Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual;
10. Any Service in connection with identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant;

The following services/supplies/expenses are also not covered:
1. Artificial heart devices.
2. Drugs used in connection with diagnosis or treatment leading to a transplant when such drugs have not received FDA approval for such use.
3. Transplant expenses that exceed the Lifetime Benefit Maximum noted on the Schedule of Benefits.

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

For approved transplant procedures, and all related complications, the Health Plan will pay benefits only for the following covered expenses:
1. Hospital expenses and physician's expenses will be paid under the Hospital Services benefit and Physician Services benefit in this Group Plan in accordance with the same terms and conditions as the Health Plan will pay benefits for care and treatment of any other covered Condition.
2. Transportation costs for the Covered Person to and from the approved facility where the transplant is to be performed if the facility is more than 100 miles from the Covered Person's home.
3. Direct, non-medical costs for one Covered Person of the Covered Person's immediate family (two Covered Persons if the patient is under age 18) for (a) transportation to and from the approved facility where the transplant is performed, but no more than one round trip per person per transplant and (b) temporary lodging at a prearranged location during the Covered Person's confinement in the approved transplant facility, not to exceed $75 per day. Direct, non-medical costs are only payable if the Covered Person lives more than 100 miles from the approved transplant facility.
4. Organ acquisition and donor costs, except as specifically covered herein for bone marrow transplants only. However, donor costs are not payable under this Group Plan if they are payable in whole or in part by any other insurance the Health Plan, organization or person other than the donor's family or estate.

5.6 MEDICAL PAYMENT GUIDELINES FOR NON-PARTICIPATING PROVIDER CARE
If the covered person requires care from a provider type that the Health Plan does not have under contract, arrangements will be made by the Health Plan to provide the appropriate care elsewhere. These services will be covered under the HMO or in-network benefits schedule for both HMO and POS members.

If the HMO Covered Person requires care from a Non-Participating Provider, and such care has been authorized, the Health Plan payment for Covered Services will be limited by the Medical Payment Guidelines then in effect. These guidelines include, but are not limited to, the following:
1. The payment of expenses for Covered Services received from Non-Participating Providers is limited to payment for services and supplies that are provided in the most cost-effective setting, procedure, treatment, supply or service. For example, services are

limited to the most cost-effective prosthetic device, orthotic device, or durable medical equipment that will restore to the Covered Person the function lost due to the Condition.

2. Payments for many services and/or supplies are included within the Allowance for the primary procedure and therefore no additional amount is payable by the Health Plan or the Covered Person for certain services and/or supplies. Examples include, but are not limited to:
   a. Payment for Physician or Health Care Provider services (e.g., Physician office and Hospital visits) is included in the allowed charge for the procedure with which the service is associated. Examples include but are not limited to surgical procedures; obstetrical care; electric shock therapy; dialysis, and therapeutic/diagnostic radiology services.
   b. The Health Plan's payment for a service includes all components of the service when the service can be described by a single procedure code, or when the service is an essential part of the associated therapeutic/diagnostic service. For example, an RBC is part of a complete blood count, and a KUB is part of a barium enema.
3. The Health Plan payment is based on the allowed charge for the actual service rendered (for example, not based on the allowed charge for a service which is more complex than the service actually rendered), and is not based on the method utilized to perform the service nor the day of the work or time of day the procedure is performed.

6.0 LIMITATION PROVISIONS

6.1 FOLLOWING ACCESS RULES

If Covered Persons do not follow the rules for accessing services and supplies described in this section, the Covered Person risks having services and supplies received not covered by this Group Plan. In such a circumstance, the Covered Person would be responsible for the entire cost of the services rendered.

Services that are provided or received without having been prescribed, directed or authorized in advance by the Health Plan when required are not covered. Except for Emergency Services and Care for an Emergency Medical Condition, all services must be received from Participating Providers, unless covered under a POS plan.

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

7.0 EXCLUSIONS AND LIMITATIONS

In addition to the limitations described in Sections 6.1 and 6.2, the following services and/or supplies are excluded from coverage, and are not Covered Services under this Group Plan. The Health Plan will not pay benefits for any of the services, treatments, items or supplies described in this Section even if such service or supply is recommended or prescribed by a provider or is the only available treatment for the Covered Employee's condition.

Abortions, including any service or supply related to an elective abortion. However, spontaneous abortions are not excluded, nor are abortions performed when the life of the mother would be endangered if the fetus were carried to term.

Alcoholism or substance abuse treatment in a Residential Treatment Facility. Inpatient and outpatient treatment is covered as described in the "Special Services" section.

Alternative Medical Treatments including but not limited to chelation therapy, massage therapy, acupuncture, and herbal remedies.

Autopsy or postmortem examination services, unless specifically requested by the Health Plan.

Biofeedback services and other forms of self-care or self-help training and any related diagnostic testing, hypnosis, meditation, and pain control.

Blood, fees associated with the collection, storage, or donation of blood or blood products, except for autologous donation in anticipation of schedule services where in the Health Plan's opinion the likelihood of excess blood loss is such that transfusion is expected adjunct to surgery.

Bloodless surgery, unless comparable outcomes, complication rates, and mortality rates are demonstrated through peer reviewed clinical studies when compared to standard surgical methods.

Breast Reduction services.

Complications of Non-Covered Services, including the diagnosis or treatment of any Condition, which arises as a complication of a non-covered service.

Cosmetic surgery (plastic and reconstructive surgery) and other services and supplies to improve the Covered Person's appearance or self-perception (except as covered under the Breast Reconstructive Surgery category), including without limitation: procedures or supplies to correct baldness or the appearance of skin (wrinkling). However the restoration of a bodily function, or the correction of a deformity resulting from disease, injury or congenital or developmental abnormalities, is covered.

Costs incurred by the Covered Person related to the following:

1. Health care services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent such services are payable under any medical expense provision of any automobile insurance policy or liability policy.
2. Telephone consultations, failure to keep a scheduled appointment, or completion of any form and /or medical information.

Custodial care, including any service or supply of a custodial nature primarily intended to assist the Covered Person in the activities of daily living. This includes rest homes, home health aides (sitters), home parents, domestic maid services, and respite care.

Dental care; Dental treatment in a hospital or ambulatory surgical center; or dental treatment for children under age 19 due to cleft palate or cleft lip are covered as specified in the Covered Services section. All other dental procedures are excluded from coverage, including extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment including palatal expansion devices, bruxism appliances and dental x-rays.

Dental Services; All dental procedures are excluded from Coverage. This exclusion includes the following: extraction of teeth, restoration of teeth with fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, dental implants, periodontal or endodontic procedures, orthodontic treatment, including palatal expansion devices, bruxism appliances and dental x-rays. Dental services related to the treatment of malocclusion or malposition of the teeth or jaws (orthognathic treatment), as well as temporomandibular joint (TMJ) syndrome or craniomandibular jaw disorders (CMJ) are also excluded. Non-dental treatments for these Conditions may be Covered if deemed Medically Necessary by the Health Plan. Additionally, dental services provided more than sixty-two (62) days after the date of an Accidental Dental Injury, regardless of whether or not the services could have been rendered within sixty-two (62) days, are excluded from Coverage.

Developmental Delay Treatment, including services and supplies necessary to improve the motor, language, social or thinking skills of a Covered Child who does not reach their developmental milestones at expected times.

Dietary regimens or treatments for reducing or controlling weight, unless specifically related to diabetic services or prescribed as part of the Health Plan's disease management programs.

Durable Medical Equipment other than the equipment specifically listed in the Covered Services section. This exclusion includes, but is not limited to: items that are primarily for convenience and/or comfort; items available over the counter; wheelchair lifts or ramps, modifications to motor vehicles and or homes such as wheelchair lifts or ramps; water therapy devices such as Jacuzzis, swimming pools, whirlpools or hot tubs; exercise and massage equipment, air conditioners and purifiers, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers, and the replacement of any such equipment unless it is non-functional and not practically repairable.

Experimental and Investigational treatment as defined in the plan Definitions section. Routine costs that would otherwise be covered if the member were not enrolled in a Clinical Trial may be covered as defined in the Covered Services Section.

Eye care, including:

1. The purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically provided for in the Covered Services section or through a Vision Rider to this Certificate.
2. Lasik, radial keratotomy, myopic keratomileusis, and any other surgery that involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.
3. Training or orthoptics, including eye exercises and vision therapy.

Food and food products including oral nutrition supplements except those listed as covered services under the Enteral/Parenteral and Oral Nutrition Therapy section.

Foot care (routine), including any service or supply in connection with foot care in the absence of disease. This exclusion includes, but is not limited to, non-surgical treatment of bunions, flat feet, fallen arches, and chronic foot strain, toenail trimming, corns and calluses.

Hearing aids (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers, unless covered under a separate rider attached to this certificate.

Home health care services, except as specifically set forth in the Covered Services section.

Hospice services, except as specifically set forth in the Covered Services section. **Hypnotism**

or hypnotic anesthesia.

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

Infertility treatment, services and supplies, including infertility testing, treatment of infertility and diagnostic procedures to determine or correct the cause or reason for the inability to achieve conception or the inability to maintain a pregnancy. 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.

Injectables, self-injectable medication, except as specifically provided for under any applicable prescription drug rider.

Learning and Developmental Services, including therapy or treatment for reading/learning disabilities. Services or treatment for mental retardation.

Massage Therapy..

Mental health services and supplies which are (a) rendered in connection with a Condition not classified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, (b) extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation and/or autism, (c) for marriage and juvenile counseling, (d) court ordered care or testing or required as a condition of parole or probation; (e) testing for aptitude, ability, intelligence or interest, or (f) cognitive remediation.

Military facility services that are eligible for coverage by the United States government, as well as any military service-connected care for which the Covered Person is legally entitled to receive from military or government facilities when such facilities are reasonably accessible to the Covered Person.

Missed appointment charges.

Non-participating provider services for HMO members**,** unless authorized in advance by the Health Plan or for emergency services and urgent care.

Obesity treatment, including bariatric surgery and medical procedures for the treatment of morbid obesity.

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

Organ Donor Organ donor treatment or services when the Member acts as the donor. Organ screening, testing for possible match/compatibility are not covered (except as specifically covered for bone marrow donors as described in the Covered Services section).

Orthomolecular therapy, including nutrients, vitamins, and food supplements.

Orthotics, including heel inserts, arch supports, orthopedic shoes, sneakers or similar type devices/appliances regardless of intended use, except for children under the age of 19 or diabetics with severe vascular disease, deformities, or diabetic foot infections. The Health Plan will cover the original arch support or orthotic device/appliance, and replacement of the device, for children under the age of 19 if the original need for the device/appliance was for congenital

deformity and if the replacement is due to growth or change. Replacements for wear and tear are not covered under any circumstances nor are ready-made compression or support hose.

Over the counter items, supplies that can be obtained without a prescription, including but not limited to slings, braces, ace bandages, elastic stockings, gauze and dressings.

Personal comfort, hygiene or convenience items, including services and supplies deemed to be not Medically Necessary and not directly related to the care of the Covered Person, including, but not limited to, beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than Medically Necessary ambulance services or other transportation services that are specifically provided for in the Covered Services section, motel/hotel accommodations, air conditioning humidifiers or physical fitness equipment.

Prescription and non-prescription drugs, including any outpatient prescription medicine, remedy, vaccine, biological product, pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, or health foods. Outpatient prescription drugs may be covered if a prescription drug rider is attached to this Certificate. The Rider will describe in detail the Coverage provided therein, and the Health Plan retains the right to modify the Rider from time to time without notice.

Private duty nursing care, except as related to and set forth in the covered home health care services provision.

Rehabilitative therapy services, including cardiac, speech, occupational and physical therapy, except as set forth in the Covered Services section. This exclusion includes any service or supply:

1. Provided to a Covered Person as an inpatient in a hospital or other facility, where the admission is primarily to provide rehabilitative services.
2. Services that maintain rather than improve a level of physical function or where it has been determined that the service will not result in significant improvement in the Covered Person's Condition within a 90-day period.
3. Long term rehabilitation therapy services in excess of 90 days per condition.
4. Services to enhance or improve athletic or work performance unrelated to functional impairment are not covered.

Residential treatment facility services, including any inpatient or outpatient services provided in a residential treatment facility.

Services, supplies, treatment, and prescription drugs that are:

1. Determined to be not Medically Necessary;
2. Not appropriately documented and/or substantiated in a corresponding medical record.
3. Not specifically listed in the Covered Services section unless such services are specifically required to be covered by federal law.
4. Court ordered care or treatment, unless otherwise covered in this Group Plan.
5. For the treatment of a Condition resulting from:
   a. War or an act of war, whether declared or not;
   b. Acts of terrorism;
   c. Participation in any act which would constitute a riot or rebellion, or a crime punishable as a felony;

d. Engaging in an illegal occupation;
e. Services in the armed forces.

6. Received prior to a Covered Person's effective date or received on or after the date a Covered Person's coverage terminates under this Group Plan, unless coverage is extended in accordance with the Extension of Benefits provision in the Administrative Provisions section.
7. Provided by a Physician or other Health Care Provider related to the Covered Person by blood or marriage.
8. Rendered from a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.
9. Non-medical conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change.
10. Supplied at no charge when health coverage is not present, such as replaced Blood, including whole blood, blood plasma, blood components, and blood derivatives, and if applicable, any charges associated with the Calendar Year Deductible, Coinsurance Percentage or Copayment requirements, which are waived by a Health Care Provider.

Sexual reassignment or modification services, including any service or supply related to such treatment, including psychiatric services and prescription drugs if covered under a drug separate rider.

[Smoking cessation programs, including any service or supply to eliminate or reduce the dependency on or addiction to tobacco unless approved in advance by the Health Plan, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.).]

Sterility Reversal, including the reversal of tubal ligations and vasectomies.

Surrogacy Services.

Training and educational programs, including programs primarily for pain management, vision training or vocational rehabilitation.

Transplantation or implantation services and supplies, including the transplant or implant, other than those specifically listed in the Covered Services section. This exclusion includes:

1. Any service or supply in connection with the implant of an artificial organ.
2. Any organ that is sold rather than donated to the Covered Person.
3. Any service or supply relating to any evaluation, treatment, or therapy involving the use of high dose chemotherapy and autologous bone marrow transplantation, autologous peripheral stem cell rescue, or autologous stem rescue for the treatment of any condition other than acute lymphocytic leukemia, acute non-lymphocytic leukemia, Hodgkin's disease, non-Hodgkin's lymphoma.
4. Any service or supply in connection with identification of a donor from a local, state or national listing, except as specifically set forth for bone marrow donors in the Covered Services section.

Transportation services that are non-emergent and not covered by Medicare.

Vision Care services as defined under the Eye Care exclusion unless a Vision Rider is attached to this Certificate. The Rider will describe in detail the Coverage provided therein, and the Health Plan retains the right to modify the Rider from time to time without notice.

Volunteer services or services that would normally be provided free of charge and any charges associated with Deductible, Coinsurance, or Copayment requirements (if applicable), which are waived by a health care provider.

Weight control services, food or food supplements, exercise equipment, and bariatric surgery.

Wigs or cranial prosthesis, except when related to restoration after cancer or brain tumor treatment.

Work related condition services to the extent the Covered Service is paid by workers' compensation through adjudication or settlement.

7.1 ADDITIONAL EXCLUSIONS AND LIMITATIONS FOR POS COVERED PERSONS

1. Outpatient Prescription Drugs are covered exclusively through the in-network benefits and are not available through non-participating providers if a Prescription Drug Rider is attached to this Certificate.
2. Emergency Services and Care are covered exclusively through the in-network benefits level.
3. Services and Supplies that are not Medically Necessary are not covered.
4. Charges in excess of the Allowable Fee Schedule are the sole responsibility of the Covered Person.

8.0 DEFINITIONS

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

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

ADMISSION DEDUCTIBLE means the amount a Covered Person pays for each Hospital Inpatient Admission before the Health Plan begins to pay any costs associated with Inpatient services.

AGENCY means the Agency for Health Care Administration.

ALLOWABLE FEE SCHEDULE means the dollar amount the Health Plan allows towards the cost of out-of-network Covered Services, unless services are authorized in advance under HMO benefits because services are not available in plan. Subscribers are responsible for any dollar amount a non-participating provider charges in excess of the Allowable Fee Schedule, which is currently based on 150% of the Health Plan's Medicare Fee Schedule. The Allowable Fee Schedule is subject to change without prior notice to affected members.

ALLOWANCE OR ALLOWED AMOUNT - For Participating Providers, this equates to the Contracted Fee Schedule. For Non-Participating Providers, this equates to a percentage of the Plan's Medicare Fee Schedule in force at the time the service is rendered. The Allowed Charge may be changed at any time without prior notice or consent.

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

AUTHORIZATION FOR SERVICES - Prior approval by the Health Plan to determine Medical Necessity is required for certain services to be covered. The physician requesting the service is required to submit all necessary clinical information along with the request to the Health Plan for review and approval.

BARIATRIC SURGERY – Surgery to treat obesity, including, but not limited to gastric banding and gastric bypass procedures, ,

BILLED CHARGES means the dollar amount billed by a Non-Participating Provider for treatment, services or supplies rendered.

BLOODLESS SURGERY - Surgical procedure requested by a member or a member's authorized representative and that is for a member who refuses a blood transfusion even though such transfusion may be medically necessary due to blood loss during the intra-operative or post-operative period. The surgical procedure uses techniques to avoid blood transfusions.

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

CALENDAR YEAR is a period of one year that starts on January 1st and ends December 31st.

COINSURANCE is the sharing of Covered health care expenses between the Health Plan and the Covered Person, as specifically set forth in the Schedule of Benefits, if applicable. Coinsurance is expressed as a percentage rather than as a flat dollar amount.

CONDITION means any sickness, injury, bodily dysfunction or pregnancy of a Covered Person. For any preventive care benefits provided in this Group Plan, Condition includes the prevention of sickness.

CONFINEMENT is an approved Medically Necessary covered stay as an inpatient in a Hospital that is:

1. Due to a Covered Condition; and
2. Authorized by a licensed medical health care provider with admission privileges.

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

CONTRACTED FEE SCHEDULE means the dollar amount the Health Plan has negotiated with participating providers for Covered Services. Covered Persons are not responsible for any dollar amount a participating provider charges in excess of this negotiated Fee Schedule.

COPAYMENT means those amounts payable by the Covered Person at the time a service is rendered. Copayment amounts, if applicable, are set forth in the Schedule of Benefits and any rider or endorsement attached to this Group Plan. The Copayment is normally expressed as a flat dollar amount and will apply in full, regardless of the amount of the actual charges or allowed amount.

COST SHARE means the amount of the Covered Person's financial responsibility as specifically set forth in the Schedule of Benefits and any rider or endorsement attached to this Group Plan. Cost Share may include any applicable combination of Deductibles, Coinsurance or Copayments up to the maximum out-of-pocket limit.

COVERED OR COVERAGE means inclusion of an individual for payment of expenses related to Covered Services under this Group Plan.

COVERED EMPLOYEE means an Eligible Employee or other individual who meets and continues to meet all applicable eligibility requirements and who is enrolled and covered under the Group Plan.

COVERED PERSON means the Eligible Employee or any Eligible Dependent included for coverage under this Group Plan. Eligibility requirements for employees and dependents are specified in the Eligibility section of this Group Plan.

COVERED SERVICES means those Medically Necessary services and supplies described in the Covered Services section of this Group Plan certificate, and any rider or endorsement attached to it.

DEDUCTIBLE means the amount of charges, up to the Allowance, for Covered Services which the Covered Person must actually pay to an appropriate licensed health care Provider, who is recognized for payment under this Group Plan, before the Health Plan's payment for Covered Services begins.

DEPARTMENT means the Florida Department of Financial Services, Office of Insurance Regulation.

DRUG means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound.

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

EFFECTIVE DATE with respect to the Small Employer and to Covered Persons properly enrolled when coverage first becomes effective, means 12:00 a.m. on the date so specified on the Group Master Plan Information Page; and with respect to Covered Persons who are subsequently enrolled, means 12:00 a.m. on the date on which coverage will commence as specified in the Eligibility and Enrollment Sections of this Group Plan.

ELIGIBLE DEPENDENT means a Covered Employee's:

1. Legal spouse; or
2. Natural, newborn, adopted, Foster, or step child (ren); or
3. A child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian;
4. A newborn child of a Covered Dependent child if properly enrolled. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

ELIGIBLE EMPLOYEE means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility section of this Group Plan and is eligible to enroll as a Covered Employee. An individual who is an Eligible Employee is not a Covered Person until such individual has actually enrolled with, and been accepted for coverage.

EMERGENCY MEDICAL CONDITION means:

1. A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

d. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus. e. Serious impairment to bodily functions.
f. Serious dysfunction of any bodily organ or part.

2. 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.

EMERGENCY SERVICES AND CARE means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

ENROLLMENT DATE means the date of enrollment of an individual in this Group Plan for coverage.

ENTERAL/PARENTERAL NUTRITION THERAPY. Enteral Nutrition Therapy involves feeding via a tube into the gastro-intestinal tract and does not include nutritional supplements taken orally in any form. Parenteral Nutrition Therapy is the provision of nutrition support intravenously, subcutaneously, intramuscularly or through some other form of injection.

EXPERIMENTAL AND INVESTIGATIONAL TREATMENT means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by the Health Plan:

1. Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health, and approval for marketing has not, in fact, been given at the time such service is furnished to the Covered Person;
2. Evidence considered reliable by the Health Plan showing that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I, or II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question.
3. Evidence considered reliable by the Health Plan and which shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question.
4. Evidence considered reliable by the Health Plan which shows that evaluation, treatment, therapy, or device has not been proven safe and effective for the treatment of the Condition in question, as evidenced in the most recently published medical literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;

Reliable evidence as defined by the Health Plan may include without limitation:

1. Reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;

2. Published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;
3. The written protocol or protocols relied upon by the treating Physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
4. The written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or
5. The records (including any reports) of any institutional review board of any institution that has reviewed the evaluation, treatment, therapy or device for the Condition in question.

GROUP PLAN means the written document, which is the agreement between the Employer and the Health Plan whereby coverage and benefits specified herein, will be provided to Covered Persons. The Group Plan includes the Certificate of Coverage, all applications, rate letters, face sheets, riders, amendments, addenda exhibits, and Schedule of Benefits that are or may be incorporated in this Plan from time to time.

HEALTH CARE PROVIDER or PROVIDERS means the Physicians, Physician's assistants, nurses, nurse clinicians, nurse practitioners, pharmacists, marriage and family therapists, clinical social workers, mental health counselors, speech-language pathologists, audiologists, occupational therapists, respiratory therapists, physical therapists, ambulance services, hospitals, skilled nursing facilities, or other health care providers properly licensed in the State of Florida.

HOME HEALTH CARE VISIT means a period of up to 4 consecutive hours of home health care services in a 24-hour period. The time spent by a person providing services under the home health care plan, evaluating the need for, or developing such plan, will be a home health care visit.

HOSPITAL means a facility properly licensed pursuant to Chapter 395 of the Florida statutes, or other state's applicable laws, that: offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

The term Hospital does not include: an ambulatory surgical center, a skilled nursing facility, stand-alone birthing centers; facilities for diagnosis, care and treatment of mental and nervous disorders or alcoholism and drug dependency; convalescent, rest or nursing homes; or facilities which primarily provide custodial, education, or rehabilitative care.

> **Note:** If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered

Services under this Group Plan. It only expands the setting where Covered Services may be performed.

INJURY means an accidental bodily injury that:

1. Is caused by a sudden, unintentional, and unexpected event or force;
2. Is sustained while the Covered Person's coverage is in force; and
3. Results in loss directly and independently of all other causes.

MEDICALLY NECESSARY - A medical service, pharmaceutical benefit or supply that is required for the identification, treatment, or management of a Condition is Medically Necessary if it is: (1) consistent with the symptom, diagnosis, and treatment of the Covered Person's medical condition and is documented as such by the treating physician; (2) widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence; (3) universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment; (4) not Experimental or Investigational; (5) not for cosmetic purposes; (6) not primarily for the convenience of the Covered Person, the Covered Person's family, the Physician, or other Provider, and (7) the most appropriate level of service, care or supply which can safely be provided to the Covered Person. If the safety and the efficacy of all alternatives are equal, the Health Plan will provide coverage for the least costly alternative. When applied to inpatient care, Medically Necessary further means that the services cannot be safely provided to the Covered Person in an alternative setting.

MEDICARE means the health insurance programs under Title XVIII of the United States Social Security Act of 1965, as then constituted or as later amended.

MEMBER means an Eligible Employee or Eligible Dependent covered under this Group Plan.

MENTAL AND NERVOUS DISORDER means any and all disorders set forth in the diagnostic categories of the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder. Examples include, but are not limited to, attention deficit hyperactivity, bipolar affective disorder, autism, mental retardation, and Tourette's disorder.

NON-PARTICIPATING PROVIDER means a Non-Participating Hospital, a Non-Participating Physician, or a Non-Participating Health Care Provider who has not made an agreement with the Health Plan to provide services to Covered Persons and is not published in the Provider Directory as “Participating”.

NURSING SERVICES means services that are provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or a license vocational nurse (L.V.N.) who is:

1. Acting within the scope of that person's license; or
2. Authorized by a Physician; and
3. Not a Covered Person of the Covered Person's immediate family.

OFFICE means the Office of Insurance Regulation.

OPEN ACCESS means covered Persons may access covered services from any participating physician without a referral from the Primary Care Physician. Note: certain specialists will not accept direct appointments from Covered Persons and require a referral to be seen.

OUTPATIENT SURGERY includes any procedure performed in an ambulatory surgery center or hospital facilities including diagnostic tests or any other minor procedures.

OUT-OF-POCKET MAXIMUM LIMIT means the maximum amount of Covered expenses each Covered Person pays every Calendar Year before benefits are payable at one hundred percent (100%) for the remainder of the Calendar Year. Certain expenditures may be excluded from the calculation such as charges over the allowed amount for POS out-of-network benefits and prescription drug cost share.

PARTIAL HOSPITALIZATION means treatment in which an individual receives at least seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a “home” for purposes of this definition.

PREVENTIVE SCREENINGS are specified tests that detect disease in individuals without current signs or symptoms of the disease. If a preventive screening test detects underlying signs or symptoms of disease then it maybe considered a "diagnostic" test instead of a "screening" and a cost share may apply.

PARTICIPATING PROVIDER means a Participating Hospital, a Participating Physician, or a Participating Health Care Provider who has made an agreement with the Health Plan to provide services to Covered Persons and is published as such in the Health Plan’s Provider Directory.

PHYSICIAN is a person properly licensed to practice medicine pursuant to Florida law, or another state's applicable laws, including:

1. Doctors of Medicine (MD) or Doctors of Osteopathy (D.O.);
2. Doctors of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.);
3. Doctors of Chiropractic (D.C.);
4. Doctors of Optometry (O.D.);
5. Doctors of Podiatry (D.P.M.).

PHYSICIAN ASSISTANT means a person properly licensed pursuant to Chapter 458 of the Florida Statutes, or a similar applicable law of another state.

POINT OF SERVICE (POS) means a benefit plan under which a Covered Person has the right to access certain medically necessary covered services from non-participating providers without a referral from the Primary Care Physician or the Health Plan. Certain services require authorization from the Health Plan to determine Medical Necessity. See “prior authorization below”.

PRIMARY CARE PHYSICIAN, a Family Practioner, Internist, Pediatrician or Physician Extender (Physician Assistant or Nurse Practitioner) licensed to provide, prescribe, and authorize care and treatment for Participants. A current listing of contracted Primary Care Physicians is published in the Plan’s Provider Directory as “Participating”.

PSYCHIATRIC FACILITY means a facility licensed to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For the purposes of this Group Plan, a psychiatric facility is not a Hospital.

SELF-EMPLOYED INDIVIDUAL means an individual or sole proprietor who derives his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS Form 1040, schedule C or F, and which generated taxable income in one of the 2 previous years.

SERVICE AREA means the geographic area described in the Service Area provision of this Group Plan, in which the Health Plan is authorized to provide health services as approved by the Agency for Health Care Administration.

SICKNESS means bodily disease for which expenses are incurred while coverage under this Group Plan is in force.

SKILLED NURSING FACILITY means an institution that meets all of the following requirements:

1. It must provide treatment to restore the health of sick or injured persons;
2. The treatment must be given by or supervised by a Physician. Nursing services must be given or supervised by a registered nurse.
3. It must not primarily be a place of rest, a nursing home or place of care for senility, drug addiction, alcoholism, mental retardation, psychiatric disorders, chronic brain syndromes or a place for the aged.
4. It must be licensed by the laws of the jurisdiction where it is located. It must be run as a skilled nursing facility as defined by those laws.

SPECIALIST means a Physician or their Physician Assistant who provides specialized services, and is not engaged in general practice, family practice, internal medicine, or pediatrics.

SMALL EMPLOYER OR EMPLOYER means the employer who has signed a Contract with the Health Plan, allowing this group health insurance coverage to be provided. To be eligible for coverage, a Small Employer means in connection with a health benefit plan with respect to a Calendar Year and a plan year, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business. The Small Employer must have its principal place of business in this state, employed an average of at least one (1) but not more than fifty (50) eligible employees on business days during the preceding Calendar Year, and employs at least one (1) employee on the first day of the plan year.

SUBSCRIBER means the Eligible Employee covered under this Group Plan.

URGENT CARE means medical screening, examination, and evaluation received in an Urgent Care Center, or rendered in a Participating Physician's office contracted for urgent care after-hours and the covered services for those conditions which, although not life-threatening, could result in serious injury or disability if left untreated. In order to receive benefits for out-of-area Urgent Care, the symptoms must not have been foreseeable prior to leaving the Service Area temporarily.

WAITING PERIOD shall mean the period of time, if any, that must pass with respect to an Eligible Employee and their dependents before coverage under this Group Plan benefits become effective. The waiting period may not exceed ninety (90) days.

WE, US, OUR means Health First Health Plans.

YOU, YOURS means the Eligible Employee or Eligible Dependent who is a Covered Person under this Group Plan.

9.0 NOTICES

9.1 WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Health Plan provides coverage under this Group Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If a Covered Person is receiving services in connection with a mastectomy, coverage is also provided for the following, as the Covered Person and the attending physician determine to be appropriate:

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

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

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

Under federal law, the Plan Sponsor generally may not restrict coverage for any hospital length of stay, in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery, or less than 96 hours, following a delivery by cesarean section. However, the Plan Sponsor may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn child earlier than the 48 or 96 hours described above.

Also, under federal law, the Plan Sponsor may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan Sponsor may not, under federal law, require that a Physician or other health care provider provide prior notification before prescribing a length of stay of up to 48 hours (or 96 hours).

9.3 STATEMENT OF EMPLOYEE RETIREMENT SECURITY ACT OF 1974

If you participate in the Health Plan through an employer that is not a religious organization or political subdivision, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance

contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
Obtain, upon written request to the plan administrator (employer), copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. Reduction or elimination of exclusionary periods of coverage for preexisting conditions
under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to

pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

9.4 FLORIDA AGENCY FOR HEALTHCARE ADMINISTRATION (AHCA)

AHCA is in the process of developing a long-range plan making available performance outcome and financial comparison data for consumers to compare health care services. The Health Plan will incorporate a link on the Health Plan's website to the AHCA information that is required by law to be available no later than March 1, 2006. The Health Plan's website address is: www.healthfirsthealthplans.org.

Member's Rights and Responsibilities

We value our relationship with you, and believe that setting clear expectations about our partnership is a critical part of earning your trust. The following rights and responsibilities represent the cornerstone of our successful future, and we encourage you to become familiar with them.

As a member, you have the right:

To receive these rights and responsibilities, as well as other information about Health First Health Plans and its benefits, services and providers.
To be treated with respect and recognition of your dignity and right to privacy. (See our Privacy Notice (PDF) for additional information on how we protect your information.) To participate with practitioners in decisions involving your health care, considering ethical, cultural and spiritual beliefs, unless concern for your health indicates otherwise. To have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage. You have the right to receive this information in terms you understand.
To receive a prompt response when you ask questions or request information.
To be informed of who is providing your medical care and who is responsible for your care.
To be informed if your health care provider plans to use experimental treatment for your care. You have the right to refuse to participate in such experimental treatment.
To receive, a reasonable estimate of charges for your medical care and a copy of an itemized bill, reasonably clear and understandable and have the charges explained to you.
To receive information about copayments and fees that you are responsible to pay.

To know what patient support services are available to you, including whether an interpreter is available if you do not speak English.
To be informed about your diagnosis, testing, treatments, and prognoses. When concern for your health makes it inadvisable to give such information to you, such information will be made available to an individual designated by your or to a legally authorized individual.
To be informed about consent to treatment, your right to refuse treatment to the extent permitted by law, and the consequences of your refusal. When refusal prevents the provision of appropriate care in accordance with ethical and professional standards, the relationship with the member may be terminated by the provider upon reasonable notice. To receive quality, timely health care with respect and compassion regardless of race, age, sex, religious beliefs, source of payment, health status, or need for health services. To receive treatment for any emergency medical condition that will get worse from failure to obtain the treatment.
To know in advance of obtaining treatment, if you are eligible for Medicare, whether the health care provider or health care facility accepts the Medicare assignment rate.
To determine the course of your treatment by issuing "advance directives." In accordance with the federal law titled "Patient Self-Determination Act" and the Florida Statute Chapter 765 titled "Health Care Advance Directives," you can make future healthcare decisions now with these types of advance directives:

- The "living will" states which medical treatments you would accept or refuse if you became permanently unconscious or terminally ill and unable to communicate.
- The "durable power of attorney for health care" or "designation of a healthcare surrogate" allow you to appoint someone else to make decisions regarding your health care when you are temporarily or permanently unable to communicate.

To have your medical records kept private, except when you provide your consent or when permitted by law.
To choose a primary doctor to coordinate your care and to change your doctor at any time.
To receive information about our quality improvement programs, including the progress being made.
To make recommendations regarding our member rights and responsibilities policies. To receive information and necessary counseling on the availability of known financial resources for your care.
To know what rules and regulations apply to your conduct.
To voice complaints or appeals about Health First Health Plans or the care provided.

Additionally, you have the responsibility:

To understand your Health First Health Plans' benefits and plan guidelines.
To supply accurate and complete information, including unexpected changes in your health condition, (to the extent possible) that Health First Health Plans and your providers need in order to provide you care.
To provide your primary doctor, to the best of your knowledge, accurate and complete information about any current medical complaints, past medical history and any other information relating to your health.
To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

To follow the plans and instructions for care that you have agreed on with your providers.

To be responsible for your actions if you refuse treatment or do not follow your health care provider’s instructions.

To follow the provider's rules and regulations affecting patient care and conduct, including keeping your appointments and arrive promptly, and notifying your physician if you're unable to keep a scheduled appointment in a timely fashion.

To your cost-sharing any other applicable fees according to your Summary of Benefits. To notify Health First Health Plans of any changes in your address, telephone number, or eligibility status.

If you are enrolled in an HMO Plan, to use the designated Health First Health Plans' network of primary care physicians, specialists, and medical facilities (except for emergency care).

Health First
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6450 US Highway 1
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myHFHP.org

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Health First Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please contact Doris Garcia-Durand.

If you believe that Health First Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Doris Garcia-Durand, ADA/Section 504 Coordinator, 6450 US Highway 1, Rockledge, FL 32955, 321-434-4521, 1-800-955-8771 (TTY), Fax: 321-434-4362, doris.garciadurand@health-first.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance Doris Garcia-Durand, ADA/Section 504 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

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36194-77150_MPINFO324 (08/2017)

Health First
Health Plans

6450 US Highway 1
Rockledge, Florida 32955
myHFHP.org

English:

If you, or someone you're helping, has questions about Health First Health Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-443-4735.

Spanish:

En caso que usted, o alguien a quien usted ayude, tenga cualquier duda o pregunta acerca de Health First Health Plans, usted tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-443-4735.

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Si oumenm oswa yon moun w ap ede gen kesyon konsènan Health First Health Plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 855-443-4735.

Vietnamese:

Nếu Quý vị, hay người mà Quý vị đang giúp đỡ, có câu hỏi về Health First Health Plans thì Quý vị có quyền được trợ giúp và được biết thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, xin gọi số 855-443-4735.

Portuguese:

Você ou alguém que você estiver ajudando tem o direito de tirar dúvidas e obter informações sobre os Health First Health Plans no seu idioma e sem custos. Para falar com um tradutor, ligue para 855-443-4735.

Chinese:

如果您，或是您正在協助的對象，有與 Health First Health Plans 相關的問題，您有權以您的母語免費取得幫助和資訊。請致電 855-443-4735 與翻譯員洽談。

French:

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Health First Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-443-4735.

Tagalog:

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Health First Health Plans, may karapatan ka na humingi ng tulong at impormasyon sa iyong wika nang libre. Upang makausap ang isang tagasalin, tumawag sa 855-443-4735.

Russian:

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Health First Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 855-443-4735.

Arabic:

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Health First Health Plans، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بالرقم 855-443-4735.

Italian:

Se lei o qualcuno che sta aiutando avete domande su Health First Health Plans, ha il diritto di ottenere aiuto e informazioni nella sua lingua gratuitamente. Per parlare con un interprete, può chiamare il numero 855-443-4735.

German:

Falls Sie oder jemand, dem Sie helfen, Fragen zum Health First Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-443-4735 an.

Korean:

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Health First Health Plans에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 855-443-4735로 전화하십시오.

Polish:

Jeśli Ty lub osoba, której pomagasz, macie pytania na temat Health First Health Plans, macie Państwo prawo do bezpłatnego uzyskania informacji i pomocy w języku ojczystym. Aby porozmawiać z tłumaczem, prosimy zadzwonić pod numer 855-443-4735.

Gujarati:

જો તમે અથવા તમે કોઇને મદદ કરી રહ્યા હો તેમાંથી કોઇને હેલ્થ ફર્સ્ટ હેલ્થ પ્લાન્સ વિશે પ્રશ્નો હોય તો તમને તમારી ભાષામાં વિના મૂલ્યે મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 855-443-4735 પર કોલ કરો.

Thai:

หากคุณหรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Health First Health Plans

คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการพูดคุยกับล่าม โปรดโทร 855-443-4735.

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36194-77150_MPINFO109 (08/2016)

Health First
Health Plans
Underwritten by Health First Commercial Plans

Small Group Value Choice POS Option VC 1
SCHEDULE OF BENEFITS

	MEMBER COST SHARE	
	In Network	***Out of Network**
ANNUAL DEDUCTIBLE Per Individual/Family	$500/$1,000	$1,000/$2,000
COINSURANCE	20%	30%
MAXIMUM OUT-OF-POCKET EXPENSE Per Individual/Family	$4,000/$8,000	$4,000/$8,000
OUT OF NETWORK FEE SCHEDULE	N/A	Health First Allowable Fee Schedule
COVERED SERVICES: Subject to limitations & exclusions as listed in the Certificate of Coverage		
OUTPATIENT SERVICES **Note:** Authorization rules may apply. Please login to our member portal at www.myhfhp.org/login to view the Authorization List.		
Preventive Services: As defined by the Affordable Care Act (*See www.healthcare.gov for a current list of covered preventive services.)*	$0	Deductible + Coinsurance
Primary Care Physician Visit	$20	Deductible + Coinsurance
Specialist Office Visit	$40	Deductible + Coinsurance
Chiropractic Services 20 visit maximum per calendar year	$20	Deductible + Coinsurance
Podiatry Services	$20	Deductible + Coinsurance
Maternity Office Visit	Deductible + Coinsurance	Deductible + Coinsurance
Maternity Ultrasounds	Deductible + Coinsurance	Deductible + Coinsurance
Diagnostic Lab Services (excludes genetic testing) (E.g. blood work) including independent clinical labs	$0	Deductible + Coinsurance

Health First
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Small Group Value Choice POS Option VC 1
SCHEDULE OF BENEFITS

	MEMBER COST SHARE	
	In Network	***Out of Network**
Genetic Testing Lab Services	Deductible + Coinsurance	Deductible + Coinsurance
Radiology Services (Per visit, per type)	Deductible + Coinsurance	Deductible + Coinsurance
Advanced Imaging Services (Per visit, per type) CT, MRI, MRA, PET, and Nuclear Studies	Deductible + Coinsurance	Deductible + Coinsurance
Allergy Injections (Per visit), (Family Physician or Specialist)	$10	Deductible + Coinsurance
Colonoscopy/Endoscopy	Deductible + Coinsurance	Deductible + Coinsurance
Vasectomy (Physician office setting)	Deductible + Coinsurance	Deductible + Coinsurance
Specialty Therapies (Chemotherapy, Radiation, Drug Infusion and IV Therapy)	Deductible + Coinsurance	Deductible + Coinsurance
Physician Office Drug Administration Fee	Deductible + Coinsurance	Deductible + Coinsurance
Emergency Room Visit (Copayment waived if admitted)	Deductible + Coinsurance	
HOSPITAL SERVICES **Note:** Authorization rules may apply. Please login to our member portal at www.myhfhp.org/login to view the Authorization List.		
Inpatient Hospital Services (Per admission)	Deductible + Coinsurance	Deductible + Coinsurance
Outpatient Surgery/Services	Deductible + Coinsurance	Deductible + Coinsurance
Outpatient Observation	$250	Deductible + Coinsurance
OTHER MEDICAL SERVICES **Note:** Authorization rules may apply. Please login to our member portal at www.myhfhp.org/login to view the Authorization List.		

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Small Group Value Choice POS Option VC 1
SCHEDULE OF BENEFITS

	MEMBER COST SHARE	
	In Network	***Out of Network**
Skilled Nursing Facility (Per admission) 120 days maximum per calendar year	Deductible + Coinsurance	Deductible + Coinsurance
Durable Medical Equipment, Orthotics, & Prosthetic Devices	Deductible + Coinsurance	Deductible + Coinsurance
Home Health Care 60 visit maximum per calendar year	Deductible + Coinsurance	Deductible + Coinsurance
Outpatient Rehabilitation Services Physical, Speech, and Occupational Therapies 20 hours per year, per condition (Authorization may be required after the benefit limit has been met when therapy is for a different condition.)	Deductible + Coinsurance	Deductible + Coinsurance
Cardiac & Pulmonary Rehabilitation 36 visit maximum per lifetime (Additional days may be authorized if medically necessary.)	Deductible + Coinsurance	Deductible + Coinsurance
Hyperbaric Oxygen Therapy	Deductible + Coinsurance	Deductible + Coinsurance
Pain Management (Per treatment day)	Deductible + Coinsurance	Deductible + Coinsurance
Inpatient Hospice Services 180 days maximum per calendar year (Benefit limit applies to inpatient and outpatient hospice services combined.)	Deductible + Coinsurance	Deductible + Coinsurance
Outpatient Hospice Services 180 days maximum per calendar year (Benefit limit applies to inpatient and outpatient hospice services combined.)	Deductible + Coinsurance	Deductible + Coinsurance
Ambulance (Medically necessary ambulance services)	Deductible + Coinsurance	Deductible + Coinsurance
All Other Covered Medically Necessary Services	Deductible + Coinsurance	Deductible + Coinsurance
Urgent Care Visit	$50	

Health First Health Plans

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Small Group Value Choice POS Option VC 1
SCHEDULE OF BENEFITS

	MEMBER COST SHARE	
	In Network	***Out of Network**
MENTAL HEALTH SERVICES **Note:** Authorization rules may apply. Please login to our member portal at www.myhfhp.org/login to view the Authorization List.		
Inpatient Mental Health Care (Per admission) 30 days maximum per calendar year	Deductible + Coinsurance	Deductible + Coinsurance
Outpatient Mental Health Care 20 visit maximum per calendar year	$20	Deductible + Coinsurance
Partial Hospitalization	$20	Deductible + Coinsurance
Inpatient Substance Abuse (Per admission) 5 days maximum per calendar year (Detox & Acute care only for alcohol/substance abuse)	Deductible + Coinsurance	Deductible + Coinsurance
Outpatient Substance Abuse Office Visit 20 visit maximum per calendar year (Alcohol/substance abuse)	$20	Deductible + Coinsurance
PRESCRIPTION DRUG BENEFIT	Included in a separate policy to be attached if applicable.	

***Out-of-Network: In addition to the applicable deductible and coinsurance, covered persons who receive services from non-participating providers shall be responsible for the difference between the non-participating provider's charge and our out-of-network allowance.**

This Schedule of Benefits is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Schedule of Benefits conflicts in any way with the Certificate of Coverage (contract), the contract shall prevail. Please review your contract for a description of services, supplies, terms and conditions of coverage.

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Gujarati:
જો તમે અથવા તમે કોઇને મદદ કરી રહ્યા હો તેમાંથી કોઇને હૅલ્થ ફર્સ્ટ હૅલ્થ પ્લાન્સ વિશે પ્રશ્નો હોય તો તમને તમારી ભાષામાં વિના મૂલ્યે મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 855-443-4735 પર કૉલ કરો.

Thai:
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คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการพูดคุยกับล่าม โปรดโทร 855-443-4735.

Health First

Health Plans

Underwritten by Health First Commercial Plans

2/15/30/50/20%

Prescriptions filled at participating retail pharmacies	30-day supply	90-day supply
Tier 1	$2	$6
Tier 2	$15	$45
Tier 3	$30	$90
Tier 4	$50	—
Tier 5	20%	—

Prescriptions filled by Health First Family Pharmacy		
Tier 1	—	$4
Tier 2	—	$30
Tier 3	—	$60
Tier 4	—	$100
Tier 5	—	—

Covered drugs

- Drugs on the formulary approved by Health First Commercial Plans, Inc.
- Drugs, medicine or medication that, under Federal or state law, may be dispensed only by prescription from a participating physician or his/her authorized representative.
- Some drugs require proof of medical necessity and prior approval by Health First Commercial Plans, Inc. See the formulary (drug list) for details.

Exclusions

- Drugs not on the formulary.
- Drugs that do not, by Federal or state law, require a prescription (i.e., over-the-counter drugs).
- Any legend drug for which a similar over-the-counter equivalent is available.
- Any drug labeled “Caution: limited by federal law to investigational use” or experimental drugs.
- Any medication that is consumed or administered at the place it is dispensed.
- Drugs for which the recipient is not charged.
- Prescription drugs for which benefits are paid under workers’ compensation or any other similar law, whether benefits are payable for all or only part of the charges.
- Prescription drugs for procedures and services that are not covered.
- Prescription orders filled prior to the effective date or after the termination date of coverage.
- Replacement of lost or damaged prescriptions.
- Drugs not approved by the Food and Drug Administration (FDA) under the Federal Food, Drug, and Cosmetic Law and regulations.
- All new drugs approved by the FDA will be excluded from the preferred drug list/formulary unless Health First Commercial Plans, Inc.’s Pharmacy and Therapeutics Committee, in its sole discretion, decides to waive this exclusion with respect to a particular drug.
- Refills in excess of the amount specified by the participating physician, refills filled before 80% of the prescription has been used (90% for controlled substances), or any refill dispensed after one year from the order of the physician
- Drugs purchased from any source (including a pharmacy) outside of the United States

CEO
Health First Commercial Plans, Inc.

Note: This is a summary of benefits only. Limitations and Exclusions may apply. Consult your Certificate of Coverage for details.

Health First

Health Plans

Underwritten by Health First Commercial Plans

Nondiscrimination Notice

Health First Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health First Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health First Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please contact Doris Garcia-Durand .

If you believe that Health First Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Doris Garcia-Durand , ADA/Section 504 Coordinator, 6450 US Highway 1, Rockledge, FL 32955, 321-434-4521, 1-800-955-8771 (TTY), Fax: 321-434-4362, doris.garciadurand@health-first.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance Doris Garcia-Durand , ADA/Section 504 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Health First Health Plans is underwritten by Health First Commercial Plans, Inc. Health First Commercial Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

Health First

Health Plans

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English:
If you, or someone you're helping, has questions about Health First Health Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-443-4735.

Spanish:
En caso que usted, o alguien a quien usted ayude, tenga cualquier duda o pregunta acerca de Health First Health Plans, usted tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-443-4735.

Haitian Creole:
Si oumenm oswa yon moun w ap ede gen kesyon konsènan Health First Health Plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 855-443-4735.

Vietnamese:
Nếu Quý vị, hay người mà Quý vị đang giúp đỡ, có câu hỏi về Health First Health Plans thì Quý vị có quyền được trợ giúp và được biết thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, xin gọi số 855-443-4735.

Portuguese:
Você ou alguém que você estiver ajudando tem o direito de tirar dúvidas e obter informações sobre os Health First Health Plans no seu idioma e sem custos. Para falar com um tradutor, ligue para 855-443-4735.

Chinese:
如果您，或是您正在協助的對象，有與 Health First Health Plans
相關的問題，您有權以您的母語免費取得幫助和資訊。請致電 855-443-4735 與翻譯員洽談。

French:
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Health First Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-443-4735.

Tagalog:
Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Health First Health Plans, may karapatan ka na humingi ng tulong at impormasyon sa iyong wika nang libre. Upang makausap ang isang tagasalin, tumawag sa 855-443-4735.

Russian:
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Health First Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 855-443-4735.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Health First Health Plans، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بالرقم 855-443-4735.

Italian:
Se lei o qualcuno che sta aiutando avete domande su Health First Health Plans, ha il diritto di ottenere aiuto e informazioni nella sua lingua gratuitamente. Per parlare con un interprete, può chiamare il numero 855-443-4735.

German:
Falls Sie oder jemand, dem Sie helfen, Fragen zum Health First Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-443-4735 an.

Korean:
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Health First Health Plans에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 855-443-4735로 전화하십시오.

Polish:
Jeśli Ty lub osoba, której pomagasz, macie pytania na temat Health First Health Plans, macie Państwo prawo do bezpłatnego uzyskania informacji i pomocy w języku ojczystym. Aby porozmawiać z tłumaczem, prosimy zadzwonić pod numer 855-443-4735.

Gujarati:
જો તમે અથવા તમે કોઇને મદદ કરી રહ્યા હો તેમાંથી કોઇને હૅલ્થ ફર્સ્ટ હૅલ્થ પ્લાન્સ વિશે પ્રશ્નો હોય તો તમને તમારી ભાષામાં વિના મૂલ્યે મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 855-443-4735 પર કૉલ કરો.

Thai:
หากคุณหรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Health First Health Plans
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการพูดคุยกับล่าม โปรดโทร 855-443-4735.